

CHAPTER 31B
HOSPITAL FINANCING

Authority

N.J.S.A. 26:2H-1 et seq., specifically 26:2H-26 and 26:2H-18d.

Source and Effective Date

R.1990 d.462, effective August 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Executive Order No. 66(1978) Expiration Date

Chapter 31B, Hospital Rate Setting, expires on August 17, 1995.

Chapter Historical Note

Chapter 31B, Hospital Rate Setting, was readopted pursuant to Executive Order No. 66(1978), as R.1990 d.462. See: Source and Effective Date. Notice of Receipt of Petition for Rulemaking. See: 24 N.J.R. 4131(a). Notice of Action on Petition for Rulemaking. See: 24 N.J.R. 4290(a).

See section annotations for specific rulemaking activity.

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SUBCHAPTER 1. GENERAL PROVISIONS

Subchapter Historical Note

Subchapter 1, formerly Hospital Rate Commission, was adopted pursuant to N.J.S.A. 26:2H-1 and became effective July 20, 1979 as R.1979 d.285. See: 11 N.J.R. 233(a), 11 N.J.R. 439(c). Pursuant to Executive Order No. 66(1978), that subchapter expired on July 19, 1984.

8:31B-1.1 Purpose and scope

The purpose of this chapter is to satisfy the requirements of the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187; and P.L. 1992, c.160, and support the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost, be available to inhabitants of the State.

Amended by R.1993 d.593, effective November 5, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Case Notes

Rate setting and review; peer comparison; reimbursement. In re: 1976 Hospital Reimbursement for Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656 (1979).

8:31B-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

“Adjusted admissions” means inpatient admissions increased to reflect outpatient activity and is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

"Base year" means the year from which historical cost data are utilized.

"Current Cost Base" means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period.

"Equalization Factor" means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs.

"Financial Elements" means those items of revenue, expenses and other data defined in N.J.A.C. 8:31B-4 for reporting to the Department of Health.

"Labor Market Area" means counties and municipalities in the State that are grouped in accordance with similar labor costs.

"Neonate" means a newborn less than 29 days of age.

"Preliminary Cost Base" means the estimated revenue a hospital may collect based on an approved schedule of rates which includes DRG rate amounts and indirect costs not included in the all-inclusive rate. Those indirect costs will either be the dollar amount specified or the estimated amount determined by a specific percentage adjustment to the rate.

"Reporting Year" means the year in which current financial and statistical data is being reported.

"Uniform Bill-Patient Summary" (also referred to as the UB-82) means a common billing and reporting form used by the hospital for each inpatient (see N.J.A.C. 8:31B-2).

"Utilization Review Committee" means a group of physicians in a designated hospital who review the health care provided to patients.

"Utilization Review Organization (URO)" means a group of physicians within a designated geographical area who review the health care provided to patients in area hospitals.

Amended by R.1991 d.158, effective March 18, 1991.
See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Definitions for full rate review and prospective operating adjustment added.

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Definition for Preliminary Cost Base revised.
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

SUBCHAPTER 2. HOSPITAL REPORTING OF UNIFORM BILL—PATIENT SUMMARIES (INPATIENT)

Subchapter Historical Note

All provisions of this subchapter were filed and became effective November 13, 1979 as R.1979 d.450. See: 11 N.J.R. 435(b), 11 N.J.R.

621(a). Amendments to this subchapter were filed and became effective August 7, 1980 as R.1980 d.361. See: 12 N.J.R. 392(d), 12 N.J.R. 517(b). Note that in order to allow time for implementing the UB-PS system, the original implementation date of September 30, 1980 was changed to January 1, 1981. This subchapter was scheduled to expire November 14, 1984. The Governor granted a waiver of the scheduled expiration date from November 14, 1984 to February 12, 1985. See: 16 N.J.R. 2733(a) (October 15, 1984 New Jersey Register). This subchapter was readopted, filed and effective on December 17, 1984 as R.1984 d.610 with amendments thereto effective January 7, 1985. See: 16 N.J.R. 2728(a), 16 N.J.R. 2733(a), 17 N.J.R. 80(b). See chapter and section levels for further amendments.

8:31B-2.1 Purpose

(a) The purpose of this subchapter is to provide the basis for a single patient data reporting system to satisfy the health planning requirements of the Health Care Reform Act of 1992 (P.L.1992, c.160). The subchapter incorporates herein by reference the National Uniform Bill (UB-92 HCFA-1450) as the common hospital billing format for all payers. The data elements and design of the form have been determined by the National Uniform Billing Committee (NUBC). The NUBC includes representatives of the Federal Government, major payers and hospital associations.

(b) This subchapter will continue to allow hospitals to:

1. Satisfy Department of Health reporting requirements for patient level clinical and financial information;
2. Allow for common and consistent reporting of revenues for services related to patient care; and
3. Promote uniformity and accuracy of patient data reporting. Confidentiality of individual patients and physicians shall be maintained in fulfilling the above purposes.

Amended by R.1984 d.610, effective January 7, 1985.

See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).

Amended by R.1993 d.362, effective July 19, 1993.

See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).

Amended by R.1994 d.488, effective September 19, 1994.

See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).

8:31B-2.2 Implementation

Beginning January 1, 1981 N.J.A.C. 8:31B-2.1, the rule on Hospital Reporting of Uniform Bill-Patient Summaries (Inpatient), has been used as a common billing and reporting mechanism for each inpatient discharged and ambulatory same day surgery outpatient treated in each hospital covered under Chapter 83, P.L. 1978.

Amended by R.1981 d.404, effective November 2, 1981.

(to become operative January 1, 1982).

See: 13 N.J.R. 410(a), 13 N.J.R. 756(c).

Added paragraph (g) 1-3.

Amended by R.1984 d.610, effective January 7, 1985.

See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).

Amended by R.1989 d.154, effective March 20, 1989.

See: 20 N.J.R. 3057(a), 21 N.J.R. 752(b).

Newborn inpatient birthweight and Severity of Illness indicators added to DRGs.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

(c)2i revised.
Amended by R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).

8:31B-2.3 Billing form

(a) The UB-92 is a multi-part form set printed in red ink. Detailed specifications are included with the UB-92 completion guidelines.

(b) The form is designed to be typed or computer printed. It will be available as unit sets or in a printed version. The number of copies in each form set will be determined by the hospital according to its planned use of the forms.

Amended by R.1984 d.610, effective January 7, 1985.
See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
Amended by R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
Amended by R.1994 d.488, effective September 19, 1994.
See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).

8:31B-2.4 Guidelines for completion of the patient billing and abstract form

(a) Procedural guidelines for completing the patient billing and abstract form follow:

1. Guidelines for completing the billing form, UB-92 HCFA-1450, have been developed by the NUBC for Medicare, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Commercial Insurers.
2. Specific instructions for Blue Cross, Medicaid, and other payers will be provided by those payers.
3. Additional data elements required for the Department of Health by this rule are described in detail by an addendum to the National Uniform Bill Manual. Note: The addendum consists of instructions for filling out the new, Federally mandated form; copies of the addendum can be obtained from the Department.

(b) Billing timelines requirements are as follows:

1. A UB-92 must be completed, finalized and submitted to the Data Intermediary for each patient within 30 days of discharge of the patient.
2. Where claims administration and cash flow considerations would dictate a more current billing than the 30 day requirement, a preliminary version of the UB-92 containing only those items required for the particular payer need be utilized at the time of billing. In interim billing cases, it is required that the full patient billing and abstract information be completed and submitted to the appropriate Data Intermediary in compliance with the Data Intermediary time limits and these rules, specifically N.J.A.C. 8:31B-2.5(g). Data items reported to the data intermediary for transmission to the Department of Health, shall not differ from data upon which payment was based.

Amended by R.1980 d.361, effective August 7, 1980.
See: 12 N.J.R. 392(d), 12 N.J.R. 517(b).
Amended by R.1981 d.404, effective November 2, 1981 (operative January 1, 1982).
See: 13 N.J.R. 410(a), 13 N.J.R. 756(c).
Item 41: Note substantially amended.
Amended by R.1983 d.598, effective December 19, 1983.
See: 15 N.J.R. 1325(a), 15 N.J.R. 2162(a).
022: New Jersey Blue Cross was "Other" New Jersey Blue Cross; reference to "Host Bank" deleted.
026: New Jersey Blue Cross was "Other" Blue Cross.
Amended by R.1984 d.610, effective January 7, 1985.
See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).
Amended by R.1989 d.154, effective March 20, 1989.
See: 20 N.J.R. 3057(a), 21 N.J.R. 752(b).
Citation error corrected.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
DRG data items to be same as payment data.
Amended by R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).
Amended by R.1994 d.488, effective September 19, 1994.
See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).

8:31B-2.5 Health data submissions to the Department of Health

(a) A data intermediary shall be selected as follows:

1. A data intermediary is the data processor approved by the Department of Health responsible for collecting, editing, generating selected reports and submitting the UB-92 data to the Department of Health.
2. A single data intermediary shall be chosen by each hospital and shall be responsible for all patients regardless of payer class. In the event that it becomes necessary to approve additional data processors, the Department will promulgate an approved list of data processors.

(b) Contractual arrangements between the hospital and the data intermediary shall include the following:

1. The contractual arrangements between a hospital and its data intermediary shall include:
 - i. Provisions for compliance with the data submission time limits specified in N.J.A.C. 8:31B-2.4(b);
 - ii. Provisions for permitting delays in such submissions to the intermediary when circumstances require;
 - iii. Provisions for resolution of any resulting disputes.
2. Provisions must not affect the ability of the intermediary to comply with the timing requirements set forth in (g) below.

(c) The contractual arrangements shall provide for the quality control measures needed to ensure accurate and reliable data submission by the hospital.

(d) To assess the accuracy and reliability of the data provided to the Department of Health, the Department of Health shall periodically audit selected records in the hospital with no attempt to tie together patient names and patient identification numbers at the Department of Health.

(e) Data shall be edited as follows:

1. The data received by the intermediary from the hospital must be edited prior to submission to the Department of Health.

i. The edits to be performed shall be agreed upon and confirmed by amendments to the current memorandum of understanding between the Department of Health and the Data Intermediaries and approved by September 30, 1994.

2. Problems detected by these edits shall be corrected by the Intermediary and the hospital.

3. Information required from the hospital by the Intermediary for edit correction must be provided within five working days of the request unless separate arrangements are made between the hospital and intermediary.

(f) Reports shall be produced as follows:

1. Each data intermediary shall produce, for the Department of Health and each hospital, a set of periodic reports which will accurately represent the data submitted by each hospital.

2. The reports to be produced will be agreed upon and confirmed by amendment to the current memorandum of understanding between the Department of Health and the data intermediaries.

3. In addition, hospitals may designate an additional organization, known as a data reporter, to assist in the verification of the accuracy and reliability of the data submitted to the intermediary. The Department of Health shall direct the data intermediary, selected under (a) above, to release a hospital's data to the reporter only upon receipt of a current signed agreement between the hospital and the data reporter. This agreement shall be updated annually, beginning September 30, 1994, and shall:

i. Indicate the hospital's designation of a data reporter;

ii. Provide for the protection of confidential data consistent with Department of Health procedures; and

iii. Allow for subsequent re-release of the data by the reporter only when the procedures, set by the Department of Health, have been followed.

4. These reports are to be used by the hospitals, in conjunction with any other information provided by their data collector or the Department of Health, to verify the accuracy and reliability of the data submitted.

5. The ultimate responsibility for the completeness and accuracy of the UB-92 data submitted to the Department of Health rests with the hospital.

6. Upon request of a payer, the final UB-92 information shall be provided to the payer, for its own cases, by the UB-92 Intermediary(ies).

(g) Data shall be submitted to the Department of Health as follows:

1. Those data elements required to be submitted to the Department of Health by each hospital through their data intermediary are described in detail in the addendum to the UB-92 guidelines.

i. These required data, edited pursuant to (e) above, shall be submitted to the Department of Health in a computer processable format and medium, specified by amendment to the current memorandum of understanding, within 90 days of the end of each calendar quarter.

ii. Each submission is to include the data on all patients discharged during the calendar quarter.

2. Records not received by the Department of Health (including corrections of fatal errors), within the time frames specified, shall be subject to a penalty of \$10.00 per record. For purposes of calculating the penalty, the total UB-92 records submitted will be compared to the total admissions and/or discharges reported on the Medicare cost report and/or Hospital Cost Forms submitted to the New Jersey Department of Health. A five percent variance will be allowed. The Department shall provide 30 days notice of its intent to close the data base, and no additional cases shall be added after that time.

3. All data submitted to the Department of Health will be edited upon receipt and any problems detected shall be corrected by the data intermediary with any necessary assistance from the hospital.

(h) All data collected by the data intermediary pursuant to this regulation are confidential in accordance with Section 1106(a) of the Federal Privacy Act of 1974 as amended by the Congressional Reports Elimination Act of 1982 (p.197-375).

(i) The intermediary(ies) shall charge the hospitals a maximum amount of \$1.45 per discharge to process hospital UB-92 data.

Amended by R.1984 d.610, effective January 7, 1985.

See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).

Substantially amended.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

No cases added to data base after closing.

Amended by R.1993 d.362, effective July 19, 1993.

See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).

Amended by R.1994 d.488, effective September 19, 1994.

See: 26 N.J.R. 10(a), 26 N.J.R. 3839(a).

8:31B-2.6 (Reserved)

Amended by R.1983 d.598, effective December 19, 1983.

See: 15 N.J.R. 1325(a), 15 N.J.R. 2162(a).

New (e)1 and (2) added; existing (e)1 made (e)3.

Repealed by R.1984 d.610, effective January 7, 1985.

See: 16 N.J.R. 2728(a), 17 N.J.R. 80(b).

SUBCHAPTER 3. FINANCIAL MONITORING AND REPORTING REGULATIONS

Subchapter Historical Note

The provisions of this subchapter were originally filed and became effective on October 17, 1979 as R.1979 d.408. See 11 N.J.R. 436(a), 11 N.J.R. 550(b). Amendments were subsequently filed as R.1979 d.484, effective December 14, 1979. See 11 N.J.R. 545(b), 12 N.J.R. 15(b). N.J.A.C. 8:31B-3.48 was completely replaced and recodified as N.J.A.C. 8:31B-5 by R.1980 d.318 effective July 17, 1980. Further amendments were filed as R.1980 d.455, effective on October 16, 1980. See: 12 N.J.R. 515(b), 12 N.J.R. 645(a). This subchapter was amended and substantially recodified (including the recodification of N.J.A.C. 8:31B-5 as N.J.A.C. 8:31B-3.78 through 3.82) by R.1981 d.494, effective January 4, 1982. See: 13 N.J.R. 486(b), 14 N.J.R. 45(a). The Executive Order No. 66(1978) expiration date for Subchapter 3 was extended by gubernatorial waiver from October 17, 1984 to October 17, 1985. See: 16 N.J.R. 2733(a). The subchapter was readopted pursuant to Executive Order 66(1978) effective October 15, 1985 with amendments effective November 4, 1985 as R.1985 d.551. See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a). Amended by R.1993 d.593, effective November 15, 1993. See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a). See chapter and section levels for further amendments.

8:31B-3.1 Statement of purpose

The following financial monitoring and reporting rules in conjunction with Financial Elements (N.J.A.C. 8:31B-4), the Uniform Cost Reporting (N.J.A.C. 8:31A-5.5) and the Rules on Hospital Reporting of Uniform Bill—Patient Summaries regulations (N.J.A.C. 8:31B-2), constitute the minimum necessary steps for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187 and P.L. 1992, c.160. These regulations should provide an environment in which to move towards the objectives of an accurate system of monitoring and reporting. This system meets the purpose of the law, to insure the citizens of New Jersey economical provision of necessary and appropriate medical services of the highest quality.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Hospital Rate Setting Commission required to retroactively correct Health Department error affecting equalization factor. *Alexian Bros. Hosp. v. State, Dept. of Health, Hosp. Rate Setting Com'n*, 242 N.J.Super. 411, 577 A.2d 164 (A.D.1989).

Hospital had statutory right to appeal rate reimbursement issues under Health Care Facilities Act. In re Amendment of N.J.A.C. 8:31B-3.31 and N.J.A.C. 8:31B-3.51, 119 N.J. 531, 575 A.2d 481 (1990).

Health Department acted within authority to establish hospital rate setting system. In re Amendment of N.J.A.C. 8:31B-3.31 and N.J.A.C. 8:31B-3.51, 119 N.J. 531, 575 A.2d 481 (1990).

In determining how to allocate reduction in Medicare payment, Hospital Rate Setting Commission was required to consider Health Care Facilities Planning Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's reduction in Medicare payments was administrative rule. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's process to allocate reduction of Medicare payments violated Administrative Procedure Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Regulations establish criteria against which Hospital Rate Setting Commission can evaluate arguments; reconciliation process not rule-making by Commission; order modification proper. In re 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

8:31B-3.2 (Reserved)

As amended, R.1983 d.597, effective December 19, 1983.
See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Footnote: rate year clarified.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Rate year defined further at (a); technology factor added at (a); citations corrected.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Certified Revenue Base added.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Preliminary cost base changed to schedule of rates.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Derivation of Schedule of Rates".

Case Notes

Costs of pension and dental plans attributed to employees in direct patient care are direct patient care costs; costs of plans attributed to indirect patient care employees are indirect patient care costs; remand to Commission for proper determination regarding plan inclusion in care cost reimbursement. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

Initial schedule of rates was issued by Commissioner on or before January 15, 1980 under former regulation. In re: *Barnet Memorial Hospital Rates*, 92 N.J. 31, 455 A.2d 469 (1983).

8:31B-3.3 Uniform Reporting: Current costs

(a) The Commissioner shall collect and review the actual costs for the institutions as reported in accordance with the Financial Elements and Reporting (N.J.A.C. 8:31B-4). Costs so reported shall be subject to revision due to subsequent audits in accordance with N.J.A.C. 8:31B-3.17.

(b) Late submission of current cost data, as defined in N.J.A.C. 8:31B-4.6(c), including Audited Financial Statements, will result in penalties of \$200.00 per working day past the appropriate submission date.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a): Cross-reference changed from N.J.A.C. 8:31A-5.5 to N.J.A.C. 8:31B-4. (b) added.

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

(b): added "including Audited Financial Statements".

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Penalty mandatory; to be reflected in next year's rates.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Exception to Administrative Procedure Act's procedural requirements did not apply to Hospital Rate Setting Commission's rate adjustment cap. *St. Barnabas Medical Center v. New Jersey Hosp. Rate Setting Com'n*, 250 N.J.Super. 132, 593 A.2d 806 (A.D.1991).

Hospital Rate Setting Commission's cap on settlement of hospital rate appeals was rule-making. *St. Barnabas Medical Center v. New Jersey Hosp. Rate Setting Com'n*, 250 N.J.Super. 132, 593 A.2d 806 (A.D.1991).

1976 Rate Review guidelines. In re: 1976 Hospital Reimbursement for Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656 (1979).

Objectives of 1979 rate review program to require hospitals to establish reasonableness of current costs incurred and increases; burden of reasonableness proof on hospital; measure is additional cost against dollar value or benefit derived; policy fringe benefits, fiscal and plant budget requests disallowed (citing former N.J.A.C. 8:31-17). In re: *Elmer Hospital*, 4 N.J.A.R. 76 (1979).

8:31B-3.4 (Reserved)

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

NON-PHY direct patient care costs deleted.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Costs per case".

8:31B-3.5 (Reserved)

Amended by R.1986 d.114, effective April 7, 1986.

See: 17 N.J.R. 2946(a), 18 N.J.R. 676(a).

Deleted "hospital" in (b).

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Stylistic changes.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Appeal reference deleted in (b); rate review added.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Development of standards".

8:31B-3.6 (Reserved)

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Incentive standard: Degree of confidence".

8:31B-3.7 (Reserved)

Amended by R.1988 d.24, effective January 4, 1988.

See: 19 N.J.R. 1145(a), 20 N.J.R. 77(a).

Amended (c): deleted "capital component for ... in N.J.A.C. 8:31B-3.27."

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Stylistic changes.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Appeal reference deleted in (b).

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Incentive standard, Preliminary Cost Base: Proposed Schedule of Rates".

Case Notes

Disincentive defined; existence of disincentives require setting of rates below costs to deter hospital inefficiency. *Riverside General*

Hospital v. New Jersey Hospital Rate Setting Commission, 98 N.J. 458, 487 A.2d 714 (1985).

8:31B-3.8 (Reserved)

8:31B-3.9 (Reserved)

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991.)

See: 23 N.J.R. 227(a).

"Accept" deleted; "implement" added.

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted without change.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Conditional proposal".

8:31B-3.10 (Reserved)

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Reference to appeals deleted.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Extraordinary expense".

8:31B-3.11 Same day surgery

(a) Same Day Surgery is considered an alternative mode of health care delivery which the Department of Health considers to be efficient and worthy of encouragement. Same Day Surgery is intended to lower the cost of health care and provide the appropriate level of care to patients who are otherwise classified as inpatients. The patient, by definition:

1. Is identified on the Uniform Bill-Patient Summary (UB-PS) as a 131 or 136 bill type in accordance with N.J.A.C. 8:31B-2.1 and discharged before midnight of the day of admission, so admission date and discharge date are the same;

2. Had surgery performed in a fully equipped operating room, for example, one routinely equipped and capable of providing general anesthesia, and identified by an operating room charge on the UB-PS;

3. Had a normal discharge, for example, was not transferred, did not leave AMA, and was not discharged dead.

Amended by R.1982, d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a), 15 N.J.R. 43(a).

Text changed from "Same day surgical units" to provide for "Same day surgery".

Amended by R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a) amended; (a) 1, 2 and 3 added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Reference to 2.1 added.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991.)

See: 23 N.J.R. 227(a).

Provision for petition for adjustment deleted at (b).

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted without change.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Reporting date in (b) changed to April 30.

8:31B-3.12 through 8:31B-3.14 (Reserved)

8:31B-3.15 (Reserved)

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Section was reserved.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Reference to appeals deleted; reference to 3.26 added.

Repealed by R.1993 d.593, effective November 5, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Certified Revenue Base".

8:31B-3.16 Current Cost Base

(a) A hospital's Current Cost Base is defined as the actual costs and revenue as identified in the Financial Elements in the base reporting period as recognized by the New Jersey Department of Health.

(b) The Current Cost Base is also used as the basis for the health care (hospital) analysis and reporting system.

(c) Hospitals' actual cost reports cannot be substituted or rearranged once the Department has determined that the actual cost submission is suitable for entry into the data base. The Department shall provide 30 days' notice of its intent to close the data base.

Amended by R.1982 d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added (d).

Amended by R.1989 d.383, effective July 17, 1989.

See: 21 N.J.R. 661(b), 21 N.J.R. 2087(a).

Added (e).

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Subsection (a) clarified. Base-year cost data base expanded in (b)4, 5 and 6, to include approved reimbursement for waste disposal costs; calculation of economic factor; and calculation of the technology factor. Cost base for 1990 rate year clarified at (b)7.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Deletion of (b)4 and (e), on 1986 cost base adjustments.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Notice to hospitals of data base closing required; no adjustments after closing.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Hospital's preliminary cost basis accommodates competing policies underlying Health Care Facilities Planning Act. *Slocum v. Hospital Rate Setting Com'n*, N.J. Dept. of Health, 240 N.J.Super. 566, 573 A.2d 971 (A.D.1990).

In determining how to allocate reduction in Medicare payment, Hospital Rate Setting Commission was required to consider Health Care Facilities Planning Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's reduction in Medicare payments was administrative rule. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's process to allocate reduction of Medicare payments violated Administrative Procedure Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Treating final reconciliation adjustments as automatic did not violate Hospital Rate Setting Commission's duty to ensure that adjustments to scheduled rates are necessary and appropriate. In *Matter of 1983 Final Reconciliation Adjustments of Greenville Hospital*, 214 N.J.Super. 607, 520 A.2d 809 (App.Div.1987).

Hospital Rate Setting Commission erred in refusing to allow hospital to recalculate number of full-time equivalent residents and residents' salaries based on accepted standard. *St. Barnabas Medical Center v. New Jersey Hospital Rate Setting Commission*, 214 N.J.Super. 599, 520 A.2d 805 (App.Div.1987).

Current cost base is a key component in the derivation of the preliminary cost base and the certified revenue base; current cost base reflects hospital's actual experiences in a given Diagnosis Related Group for the base year; rate setting procedure review; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

Commission's denial of inclusion of employee pension and dental plans in reimbursement rate calculation not supported by record; remand to Commission for proper determination. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

Regulations explain criteria to determine reasonableness of proposed hospital budgets; 1979 minimum base period challenge disallowed; uncompensated services not reimbursable cost but deduction from revenue; other general services; calculation using economic factor formula (citing former N.J.A.C. 8:31-17). In re: *Millville Hospital*, 6 N.J.A.R. 456 (1980).

8:31B-3.17 Financial elements reporting/audit adjustments

(a) The aggregate Current Cost Base is developed from financial elements reported to New Jersey State Department of Health and includes:

1. Costs related to patient care (as defined in N.J.A.C. 8:31B-4.32);
2. Less net income from specified sources (as defined in N.J.A.C. 8:31B-3.25); and
3. Capital Facilities Costs: Capital cash requirements (as defined in N.J.A.C. 8:31B-4.21).

(b) All reported financial information shall be reconciled by the hospital to the hospital's audited financial statement. In addition, having given adequate notice to the hospital, the Department of Health may perform a cursory or detailed on-site review at the Department's discretion of all financial information and statistics to verify consistent reporting of data and extraordinary variations in data relating to the development of the Current Cost Base (CCB). Any adjustments made subsequent to the financial review (including Medicare and Medicaid audits and New Jersey State Department of Health reviews) shall be brought to the attention of the Commissioner by the hospital, the Department of Health, appropriate fiscal intermediary or payer where appropriate and shall be applied proportionately to the Cost Base.

(c) Hospitals shall submit a complete list of exceptions to the proposed audit adjustments, together with appropriate written documentation, within 60 days of receipt of the Department's written summary of these adjustments, or these adjustments shall be implemented in accordance with (b) above. Consideration shall be given only to documentation submitted in accordance with this schedule.

Amended by R.1982 d.427, eff. December 6, 1982.
See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).
Amended (b) to permit cursory or detailed review.
Amended by R.1984 d.531, eff. November 19, 1984 (operative January 1, 1985).
See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).
(b): Added "net"; deleted "for each individual discrepancy".
Amended by R.1988 d.24, effective January 4, 1988.
See: 19 N.J.R. 1145(a), 20 N.J.R. 74(a).
Deleted text in (a)3 "plus a formula allowance".
Amended by R.1991 d.158, effective March 18, 1991.
See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
References to 3.25 and 3.40 added; audit adjustment provisions added at (c) and (d).
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Hospital Rate Setting Commission required to retroactively correct Health Department error affecting equalization factor. Alexian Bros. Hosp. v. State, Dept. of Health, Hosp. Rate Setting Com'n, 242 N.J.Super. 411, 577 A.2d 164 (A.D.1989).

8:31B-3.18 (Reserved)

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Mixed costs deleted; exception added at (b).
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Section was "Identification of direct and indirect costs related to patient care".

Case Notes

Regulation provides precise method of cost allocation between direct and indirect patient care costs; remand to Commission for proper determination regarding inclusion of employee pension and dental plans in care cost reimbursement. Riverside General Hospital v. New Jersey Hospital Rate Setting Commission, 98 N.J. 458, 487 A.2d 714 (1985).

8:31B-3.19 (Reserved)

Amended by R.1983 d.194, effective June 6, 1983.
See: 14 N.J.R. 737(a), 15 N.J.R. 919(a).
Amended footnotes.
Amended by R.1983 d.597, effective December 19, 1983.
See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).
(a) and (b): deleted references to medical discharge abstracts.
(a) 4: "Same Day Surgical Services" made a clinical service.
Correction: 16 N.J.R. 2848(b).
The dates in footnotes 1 and 2 have been changed from "1985" to "1986".
Notice: Footnotes 1, 2 and 3 have been amended.
See: 17 N.J.R. 2465(a).
Amended by R.1985 d.551, effective November 4, 1985.
See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).
(a)4 added.
Misc. Notice: Footnotes 1, 2 and 3 have been amended.
See: 19 N.J.R. 249(b).
Amended by R.1989 d.77, effective February 6, 1989.
See: 20 N.J.R. 2541(a), 21 N.J.R. 295(a).

Deleted "BCU" from footnote 1.
Amended by R.1989 d.153, effective March 20, 1989.
See: 20 N.J.R. 3057(b), 21 N.J.R. 753(a).
Birthweight (newborn) and Severity of Illness indicators added to DRGs.
Amended by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
Effective dates deleted from (a)lvii; footnotes regarding RIMs deleted.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Indirect costs added; PCB changed to schedule of rates.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Section was "Patient care cost findings: Direct costs per case, physician and nonphysician".

8:31B-3.20 (Reserved)

Amended by R.1991 d.158, effective March 18, 1991.
See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
"Update" factors substituted for "projected economic" factors.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Reference to 1.2 added.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Section was "Preliminary Cost Base".

8:31B-3.20A through 8:31B-3.20C (Reserved)

8:31B-3.20D (Reserved)

R.1981 d.290, eff. July, 1981.
See: 13 N.J.R. 266(b), 13 N.J.R. 486(d).
Repealed by R.1985 d.551, effective November 4, 1985.
See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).
Was "Calculation on return of investment: For-Profit Hospitals".

8:31B-3.21 (Reserved)

Amended by R.1991 d.158, effective March 18, 1991.
See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
"Update" factors substituted for "economic" factors.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Section was "Reasonable Cost of Services Related to Patient Care".

8:31B-3.22 (Reserved)

Amended by R.1983 d.597, effective December 19, 1983.
See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).
(b)liii: "Pediatrics" and principal residencies requirement added.
(b)6 deleted; N.J.A.C. 8:31B-3.24(c) added to (d)1; labor Market Area language deleted from (d)2ii; (d)3 and 4 deleted.
Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).
See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).
(b)lii: "45" was "35"; iii: "Twenty-five" was "Twenty" and "12.5" was "10".
Amended by R.1985 d.551, effective November 4, 1985.
See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).
Deleted text "respectively" and substituted "whose costs are included in the data base".
Amended by R.1986 d.114, effective April 7, 1986.
See: 17 N.J.R. 2946(a), 18 N.J.R. 676(a).
Deleted "hospital" and added "cost per case" in (d).
Amended by R.1987 d.402, effective October 5, 1987.
See: 19 N.J.R. 605(a), 19 N.J.R. 1797(b).
Added (b)6 and 7.
Amended by R.1988 d.277, effective June 20, 1988.
See: 20 N.J.R. 594(a), 20 N.J.R. 1428(b).
Added text to (b)6 "To be similarly included, ..." and added text to (b)6iii "in the State of New Jersey" and ", and passage of ..."

Amended by R.1989 d.387, effective July 17, 1989.
 See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).
 Labor market areas recognized in 1988 rate setting retained for 1989 rate year, in (c).
 Amended by R.1989 d.388, effective July 17, 1989.
 See: 21 N.J.R. 1059(a), 21 N.J.R. 2082(a).
 Reimbursement for Direct Patient Care Costs to be based on DRG rates which are adjusted to reflect their residency mix by specialty program, based on the methodology in Appendix XI.
 Amended by R.1990 d.36, effective January 16, 1990.
 See: 21 N.J.R. 3275(a), 22 N.J.R. 205(b).
 Eleven areas used for rate setting retained for years subsequent to 1989.
 Amended by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Accreditation required in (b)7; labor market updated to 1990 in (d)2.
 Amended by R.1991 d.158, effective March 18, 1991.
 See: 22 N.J.R. 3724(a), 22 N.J.R. 898(a).
 Requirements for resident transfers added at (b)9.
 Public Notice: Notice of receipt of petition for rulemaking to eliminate the Newton-Phillipsburg labor market area and include Sussex and Warren Counties.
 See: 23 N.J.R. 2545(e).
 Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 Teaching costs changed by deletion of (b)1-5, for indirect; addition of (c)2ii, for direct; neutralization and equalization factors added at (c)3-4 and (d)8.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Standard costs per case".

8:31B-3.23 (Reserved)

Annotations on "Reasonable direct cost per case":
 Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).
 See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).
 Substantially amended.
 Amended by R.1985 d.551, effective November 4, 1985.
 See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).
 (d) added.
 Amended by R.1989 d.338, effective July 17, 1989.
 See: 21 N.J.R. 1059(a), 21 N.J.R. 2082(a).
 Direct Patient Care Costs to be based on DRG rates which are adjusted to reflect their residency mix by specialty program, based on the methodology in Appendix XI.
 Amended by R.1990 d.38, effective January 16, 1990.
 See: 21 N.J.R. 3275(b), 22 N.J.R. 206(a).
 Requirements added for multi-tiered pricing system for Chapter 83 hospitals, pursuant to N.J.S.A. 26:2H-18.4 et seq.
 Annotations on "Reasonable indirect patient care costs":
 Amended by R.1982 d.427, effective December 6, 1982.
 See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).
 Screening methodology to be compared with 1979 actual cost data. Also added (e).
 Amended by R.1983 d.597, eff. December 19, 1983.
 See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).
 (b): "base year" was "1979".
 Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).
 See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).
 Substantially amended.
 Amended by R.1988 d.25, effective January 4, 1988.
 See: 19 N.J.R. 1147(a), 20 N.J.R. 82(a).
 Substantially amended.
 Amended by R.1989 d.387, effective July 17, 1989.
 See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).
 Standard reimbursement changed to 100% for certain cost centers. Reimbursement of other centers not subject to screening and/or volume variability.
 Appeal for unit costs added to (c), at 6. Old 6 text recodified to 7 and information on additional refinements to indirect costs reimburse-

ment methodology added. Revisions of cost centers chart at (e), to correctly reflect Education and Research cost center.
 Amended by R.1989 d.388, effective July 17, 1989.
 See: 21 N.J.R. 1059(a), 21 N.J.R. 2082(a).
 Language added at (c)3 regarding loss of program accreditation and reclassification.
 Amended by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Text at (c)4 corrected to "base year"; formula and appeals process for unequalized standard unit cost calculation deleted at (c)5.
 Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).
 See: 23 N.J.R. 227(a).
 Text at (c)1 through 6 deleted; revised text added at (c)1 through 4, to implement revised appeal process.
 Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.
 See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).
 Provisions of emergency amendment R.1991 d.42 readopted without change.
 Amended by R.1993 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 Coefficient of variation changed at (a)1; (f)-(m) added to create "Reasonable cost per case."
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Reasonable cost per case".

Case Notes

Direct patient care cost incentives and disincentives determined by comparing historic or base year costs for each separate Diagnosis Related Group (DRG) to peer group standard for each DRG; remand to Commission for proper determination regarding inclusion of employee pension and dental plans in care cost reimbursement. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

8:31B-3.24 Off-site primary care

The Commissioner may establish demonstration projects involving hospital-affiliated off-site outpatient facilities providing primary care under an agreement with the Department of Health. For hospitals selected to participate in such programs, there may be reporting requirements, as defined in rules by the Department of Health, to evaluate these programs.

Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 Text on reasonable indirect patient care costs transferred to 3.23; text on off-site primary care added as new rule.
 Amended by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-3.25 Net income from other sources

(a) The net gain (loss) from Other Operating and Non-Operating Revenues (as defined in N.J.A.C. 8:31B-4.61 through 4.67), and expenses of the reporting period which are items considered as recoveries of or increases to the Costs Related to Patient Care (see N.J.A.C. 8:31B-4.61 through 4.67) as reported to the New Jersey State Department of Health are subtracted from (added to) costs of the Preliminary Cost Base/Certified Revenue Base.

(b) Such revenue for PCBs/CRBs established using data from the Uniform Cost Reporting Regulation shall include all Other Operating and Non-Operating Revenues and Expenses reported per SHARE cost center costs and "expense recoveries" as Case B (see N.J.A.C. 8:31B-4.61 through 4.67), and all other items reported per the Uniform Cost Reporting Regulation as to their Case specified in N.J.A.C. 8:31B-4.61 through 4.67.

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Certified revenue base added.

8:31B-3.26 Update factors

(a) Economic Factor: An economic factor shall be calculated for each hospital. It shall take into account the level of hospital expenses and replacement cost of major moveable equipment, using the cost components reported to the New Jersey State Department of Health. The economic factor is the measure of the change in the prices of goods and services used by New Jersey hospitals. The economic factor shall be based, as far as possible, on recorded price changes. For that part of the period covered by the economic factor for which recorded prices are unavailable, the economic factor shall be based on the best available forecast of price trends.

1. The economic factor shall be determined by the Commissioner of Health prior to the beginning of each year.

2. The economic factor calculation shall include the most current measure of inflation/deflation and will reflect changes in a fixed market basket of goods as determined by the Commissioner. The economic factor should not take into account changes in technology or disease entities as these are adjusted through the technology factor.

(b) Cost Change Factor: An actual cost change factor shall be calculated for each hospital, in accordance with N.J.A.C. 8:31B-4. It shall take into account the level of hospital expenses and replacement costs of major moveable equipment, using the cost components reported to the New Jersey State Department of Health. The actual cost change factor is the actual measure of the change in the prices of goods and services used by New Jersey hospitals, to be based upon reported expenses.

(c) Technology Factor: The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost increasing technologies. Allowances for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-

decreasing technologies identified by ProPAC will be included, if available.

Amended by R.1983 d.206, effective June 6, 1983.
See: 15 N.J.R. 471(a), 15 N.J.R. 920(a).

In (a), changed how economic factor is calculated. Deleted old (b)1-2 and added new (b). Added (c).

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

Reference to Appendix II (cost components) added.

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Labor 1 costs capped at 6%. For 1989, labor proxy changed to blend of Bureau of Labor Statistics Index and regional data.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Text on labor proxy, specific years and (a)3 deleted; reference to 3.72(a)1 added; (a)1ii adjusted.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).

See: 23 N.J.R. 227(a).

"Accept" deleted; "implement" added; (c) through (i) (Prospective opening adjustment) added.

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted with change effective March 18, 1991.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Basis of economic factor deleted, new basis added at (a)5, (e), (i)-(1) added; reference to 1992 added to (f) and (g).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-3.27 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added "Dodge Construction System Costs".

Also deleted old and added new v to (a)1. Footnotes also amended.
Amended by R.1983, d.200, effective June 6, 1983.

See: 15 N.J.R. 201(a), 15 N.J.R. 920(b).

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a)1vi: 10 percent penalty added for not maintaining Plant Fund level.

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

Substantially amended.

Amended by R. 1985 d.551, effective November 4, 1985.

See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Substantially amended.

Amended by R.1988 d.34, effective January 4, 1988.

See: 19 N.J.R. 1145(a), 20 N.J.R. 77(a), 21 N.J.R. 1827(a).

Substantially amended.

Amended by R.1990 d.40, effective January 16, 1990.

See: 21 N.J.R. 3278(a), 22 N.J.R. 211(a).

Construction costs per bed based on the determination of the Department, rather than the Dodge Report.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Capital Facilities".

8:31B-3.28 (Reserved)

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Footnotes placed in text at (b)1-3; infusion of working capital clarified at (a).

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

CRB provisions added.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Calculation of initial infusion of working capital".

8:31B-3.29 (Reserved)

Amended by R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Text of (b) replaced; (c) added.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Calculation of Return on Investment-for-Profit Hospitals".

8:31B-3.30 (Reserved)

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Adjustments for extraordinary expense".

8:31B-3.31 (Reserved)

Amended by R.1986 d.138, effective April 21, 1986.

See: 17 N.J.R. 2947(a), 18 N.J.R. 843(b).

(b) added.

Amended by R.1986 d.260, effective July 7, 1986.

See: 18 N.J.R. 795(b), 18 N.J.R. 1379(c).

(c) added.

Amended by R.1987 d.402, effective October 5, 1987.

See: 19 N.J.R. 605(a), 19 N.J.R. 1797(b).

(b) substantially amended.

Amended by R.1988 d.277, effective June 20, 1988.

See: 20 N.J.R. 594(a), 20 N.J.R. 1428(b).

Deleted text in (b) "The Commission shall . . . July 1, 1985.", and the effective date of January 1, 1988; also deleted text in (c) "A hospital must . . . positions by transfers"; and added text "or increase".

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Provisions for adjustment for residents amended; appeals deleted; reference to 3.22 added.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Modifications to be added in following rate year; physician compensation changes to be reported within 30 days.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Commission adjustments and approvals".

8:31B-3.32 (Reserved)

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Section was reserved.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Rate review provisions added.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Overspending challenge".

8:31B-3.33 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Deleted old (a) and (b) and added new (a)-(c).

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Old (a) and (b) replaced with new (a); existing (c) became (b).

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Alternate methodology".

8:31B-3.34 (Reserved)

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text on Medicare cost shift added as new.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Medicare cost shift".

8:31B-3.35 (Reserved)

Petition for Rulemaking: Petition from N.J. Hospital Assoc., requesting a rule to be known as "Non-resident care costs."

See: 24 N.J.R. 4131(a), 24 N.J.R. 4290(a), 25 N.J.R. 4676(b).

8:31B-3.36 (Reserved)

8:31B-3.37 (Reserved)

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Schedule of Rates".

8:31B-3.38 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

In (b)3 review and approval time period changed from 15 to 30 working days.

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

Substantially amended.

Amended by R. 1985 d.551, effective November 4, 1985.

See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Substantially amended.

Amended by R.1986 d.477, effective December 15, 1986 (operative January 1, 1987).

See: 18 N.J.R. 1911(a), 18 N.J.R. 2447(a).

Deleted text in (c)2ii "The rate is . . . of the stay" and substituted "The rate is . . . low per diem."

Amended by R.1987 d.338, effective August 17, 1987.

See: 19 N.J.R. 840(a), 19 N.J.R. 1545(a).

Added footnote **** to Schedule of Rates in (c).

Amended by R.1989 d.153, effective March 20, 1989.

See: 20 N.J.R. 3057(d), 21 N.J.R. 753(a).

Definitions added and recodified to clarify outlier categories.

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Operating margin added at (a)3.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Dialysis deleted from (c)1; (c)2iv, on clinical outliers, deleted.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).

See: 23 N.J.R. 227(a).

Operating adjustment changed from one percent to two percent for 1991 and beyond.

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted without change.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text at (a)3 deleted; revision of (b)4 to include PCB/CRB; specific payer differentials added; (e) added.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Derivation from Preliminary Cost Base".

8:31B-3.39 (Reserved)

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

New (b) added; existing (b) made (c).

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Inclusion of payer differentials and payer adjustments".

8:31B-3.40 (Reserved)

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(k): "Once the UB-PS becomes effective" deleted from second sentence.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text on 1% discount deleted at (g).

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Changes in working capital".

8:31B-3.41 (Reserved)

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a)1 added.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Uncompensated care."

8:31B-3.42 (Reserved)

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Deleted original language concerning implementation.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).

See: 23 N.J.R. 227(a).

Appeal provision deleted; full rate review added at (b).

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted with change effective March 18, 1991.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Schedule of rates—effective date".

8:31B-3.43 Adjustment of charges

(a) A hospital shall submit to the Commissioner a copy of its charges in use during the current year for review and monitoring purposes.

(b) A hospital must notify the Commissioner of any charges adjusted throughout the year which alter overall estimates of net revenue to be collected.

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added plus or minus variances of 20 percent in the third 12 months.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Substantially amended.

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

(b): "15" was "20".

Amended by R.1989 d.79, effective February 6, 1989.

See: 20 N.J.R. 2542(a), 21 N.J.R. 296(a).

Substituted "30" for "45" and "fifteen" for "thirty".

Correction: Text, "subsidization and how . . . Schedule of Rates." in (d) was inadvertently dropped from the 3-20-89 Update.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Working days changed to calendar days.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-3.44 (Reserved)

Amended by R.1989 d.80, effective February 6, 1989.

See: 20 N.J.R. 2542(b), 21 N.J.R. 296(b).

Substantially amended.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Billing exceptions".

8:31B-3.45 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Changed from 1983 to 1985 date hospitals to begin submitting Uniform Bill—Patient Summaries.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a): last two sentences added.

Amended by R.1984 d.598, effective January 7, 1985.

See: 16 N.J.R. 2733(c), 17 N.J.R. 83(a).

(a): Date changed from "1985" to "1988".

Amended by R.1988 d.497, effective October 17, 1988.

See: 20 N.J.R. 1143(a), 20 N.J.R. 2574(a).

(a): Changed date from "1988" to "1990".

Amended by R.1989 d.153, effective March 20, 1989.

See: 20 N.J.R. 3057(b), 21 N.J.R. 753(a).

Newborn birthweight and Severity of Illness indicators added to DRG reporting requirements.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Reference to 2.2 and to outpatients added; fine provision deleted.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Uniform Bill—case mix determination—financial reports".

8:31B-3.46 through 8:31B-3.50 (Reserved)

8:31B-3.51 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Notification by hospitals changed from 60 to 45 days. Added one percent of all direct patient care costs and included as a mark-up factor. Also added "2. Conditional Accept" to (b).

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).

See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).

Substantially amended.

Amended by R.1985 d.551, effective November 4, 1985.

See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Substituted "10" working days for "five".

Amended by R.1986 d.138, effective April 21, 1986.

See: 17 N.J.R. 2947(a), 18 N.J.R. 843(b).

(b)4 added.

Amended by R.1987 d.402, effective October 5, 1987.

See: 19 N.J.R. 605(a), 19 N.J.R. 1797(b).

Added text in (b)2 "In evaluating appeals . . . by medical schools."

Deleted Note and added (b)2i(4).

Amended by R.1988 d.24, effective January 4, 1988.

See: 19 N.J.R. 1145(a), 20 N.J.R. 77(a).

Substantially amended.

Amended by R.1988 d.25, effective January 4, 1988.

See: 19 N.J.R. 1147(a), 20 N.J.R. 82(a).

Added text to (b)1 "and in 1988 only 8:31B-3.24".

Amended by R.1988 d.277, effective June 20, 1988.

See: 19 N.J.R. 594(a), 20 N.J.R. 1428(b).

Added to (b)1 "and 8:31B-3.31(c)" and added to (b)4 "statewide increases in".

Amended by R.1989 d.385, effective July 17, 1989.

See: 21 N.J.R. 131(b), 21 N.J.R. 2073(a).

At (b) changed notification from 45 to 30 days; at (b)1 added i-vi delineating those costs that are appealable and repealed the paragraph 2 regarding the option to conditionally accept the Certified Revenue Base and at new 2 recodified from 3, further clarified the option not to accept.

Amended by R.1990 d.41, effective January 16, 1990.

See: 21 N.J.R. 3278(b), 22 N.J.R. 212(a).

Reference to specific years deleted; hospitals now allowed to appeal under the Accept option any Hospital Rate-Setting Commission approved continuing adjustments not captured in a base year because the adjustments were approved between the base year and the first year of implementation.

Administrative Correction: Added (b)3.

See: 22 N.J.R. 1576(b).

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Provision for Commission-approved adjustments added at (b)1 and 3; reference to 1989 corridor deleted.

Emergency repeal and new rule, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).

See: 23 N.J.R. 227(a).

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted without change.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Rate review text added at (c).

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Rate notification, approval, and implementation".

Case Notes

Regulations through N.J.A.C. 8:31B-3.65 provide appeals process to allow hospitals to seek adjusted increases to preliminary cost base for a given rate year; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

Compliance with rate appeal procedure under former N.J.A.C. 8:31B-3.32. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

8:31B-3.52 (Reserved)

Amended by R.1989 d.385, effective July 17, 1989.

See: 21 N.J.R. 131(b), 21 N.J.R. 2073(a).

Language regarding documentation of exception deleted and replaced with new (b); old (b) and (c) recodified as (c) and (d). Emergency repeal and new rule, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).

See: 23 N.J.R. 227(a).

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted with change effective March 18, 1991.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Department to initiate a rate review when necessary to support statutory requirements for service provision; hospital to provide documentation within 30 days of notice.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Full rate review".

Case Notes

Any approved rate adjustment is subject to reconciliation process; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

8:31B-3.53 (Reserved)

Amended by R.1982 d.437, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Changed manner in which exceptions are determined from use of SHARE guidelines to justification by full dollar value of cost and benefits.

As amended, R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Cross-reference clarified.

Repealed by R.1989 d.385, effective July 17, 1989.

See: 21 N.J.R. 131(b), 21 N.J.R. 2073(a).

Rule formerly entitled "Operating costs: Retrospective exceptions".

8:31B-3.54 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Changed manner in which exceptions are determined from use of SHARE guidelines to justification by full dollar value of cost and benefits.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(a)1: "Clinical rate" was "DRG"; (a)liii added. Text of (a)2 replaced.

Amended by R.1986 d.114, effective April 7, 1986.

See: 17 N.J.R. 2946(a), 18 N.J.R. 676(a).

Deleted "hospital" and inserted "cost per case" in (a)3.

Repealed by R.1989 d.385, effective July 17, 1989.

See: 21 N.J.R. 131(b), 21 N.J.R. 2073(a).

Rule formerly "Operating costs: Prospective Exceptions".

8:31B-3.55 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added "N.J.A.C. 8:31B-4.66(e) of 1983 Financial Elements" to (d).

Amended by R.1988 d.24, effective January 4, 1988.

See: 19 N.J.R. 1145(a), 20 N.J.R. 77(a).

Deleted text in (a) "prior to their ..." and substituted "in accordance with ...".

Amended by R.1989 d.385, effective July 17, 1989.

See: 21 N.J.R. 131(b), 21 N.J.R. 2073(a).

Deleted reference to "Conditional Accept" and added reference to Certified Revenue Base.

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).

See: 23 N.J.R. 227(a).

Text at (b) and (d) deleted to remove appeal provision.

Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.

See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).

Provisions of emergency amendment R.1991 d.42 readopted without change.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Section was "Capital facilities".

8:31B-3.56 (Reserved)

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Text on revenue adjustments repealed.

8:31B-3.57 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).
 Text changed from "Same Day surgical units" to provide for "Same day surgery".
 Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).
 See: 23 N.J.R. 227(a).
 Appeal provision deleted.
 Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.
 See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).
 Provisions of emergency amendment R.1991 d.42 readopted with change effective March 18, 1991.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Same day surgery".

8:31B-3.58 (Reserved)

Amended by R.1983 d.597, effective December 19, 1983.
 See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).
 (b): Clinical Rate language added and subsection substantially amended and recodified.
 Repeal and New Rule, R.1989 d.385, effective July 17, 1989.
 See: 21 N.J.R. 131(b), 21 N.J.R. 2073(a).
 Rule formerly entitled "Statewide adjustments".
 Emergency repeal, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).
 See: 23 N.J.R. 227(a).
 Appeal provision deleted.
 Repealed by R.1991 d.158, effective March 18, 1991.
 See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
 Text on Statewide and clinical legal appeals deleted.

8:31B-3.59 (Reserved)

R.1989 D.385, effective July 17, 1989.
 See: 21 N.J.R. 131(b), 21 N.J.R. 2073(b).
 Emergency repeal, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).
 See: 23 N.J.R. 227(a).
 Appeal provision deleted.
 Amended by R.1991 d.158, effective March 18, 1991.
 See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
 Text on hospital-specific clinical rate appeals deleted.

8:31B-3.60 (Reserved)

R.1989 D.385, effective July 17, 1989.
 See: 21 N.J.R. 131(b), 21 N.J.R. 2073(b).
 Repealed by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Text on temporary revenue adjustments repealed.

8:31B-3.61 through 3.62 (Reserved)

8:31B-3.63 (Reserved)

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).
 See: 23 N.J.R. 227(a).
 Review and appeal; provisions deleted; final Commission decision to be rendered in 120 days.
 Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.
 See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).
 Provisions of emergency amendment R.1991 d.42 readopted with change effective March 18, 1991.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Commission: Procedures".

8:31B-3.64 (Reserved)

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Modification of proposed Schedule of Rates".

Case Notes

Commission has inherent authority to take action consistent with its legislative mandates even when not expressed in regulations or where strict regulatory compliance would produce mandate-contrary results in a given case; reconciliation function is meant to be adjudicatory as case-by-case flexibility is required; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

Incentive defined; incentives establish amount rates can exceed costs. Riverside General Hospital v. New Jersey Hospital Rate Setting Commission, 98 N.J. 458, 487 A.2d 714 (1985).

8:31B-3.65 (Reserved)

Emergency amendment, R.1991 d.42, effective December 31, 1990, operative January 1, 1991 (expires March 1, 1991).
 See: 23 N.J.R. 227(a).
 Appeal and interim provisions deleted.
 Adopted Concurrent Proposal R.1991 d.157, effective February 25, 1991.
 See: 23 N.J.R. 227(a), 23 N.J.R. 889(a).
 Provisions of emergency amendment R.1991 d.42 readopted with change effective March 18, 1991.
 Emergency amendment, R.1991 d.506, effective September 16, 1991 (expires November 15, 1991).
 See: 23 N.J.R. 2881(a).
 Text added at (b); old (b) recodified to (c).
 Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 Reference to 1991 deleted.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Schedule of Rates Adjustments".

8:31B-3.66 Commission fees

(a) A charge of up to \$5.00 per adjusted admission, as defined by the American Hospital Association, for each adjusted admission in the year of the current cost base, shall be assessed each institution for which the Commission determines a preliminary cost base.

(b) An adjusted admission, as defined by the American Hospital Association, means admissions multiplied by total gross revenue divided by inpatient gross revenue.

Amended by R.1982 d.427, effective December 6, 1982.
 See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).
 Fee increased from \$.50 to \$1.00.
 Amended by R.1983 d.597, effective December 19, 1983.
 See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).
 \$2.00 fee was \$1.00.
 Amended by R.1989 d.472, effective September 5, 1989.
 See: 21 N.J.R. 1606(a), 21 N.J.R. 2787(a).
 Fee changed from \$2.00 to \$5.00.

8:31B-3.67 through 8:31B-3.69 (Reserved)

8:31B-3.70 Revenue Cap

(a) The Hospital Rate Setting Commission will establish the maximum amount a hospital may collect in revenues in 1993 from all payers.

(b) Collected revenue will be calculated as follows:

Gross Patient Service Revenues	_____
Less Excluded Services	_____
Less Current Year Payer Allowances	_____

Less Medicare Allowances	_____
Less Uncompensated Care	_____
Less Prompt Payment Discounts	_____
Less Personnel Health Allowance	_____
Less Medical Denials Allowances	_____
Less Nursing Home Placement Allowances	_____
Less Courtesy Adjustments	_____
Less Other Administrative Adjustments	_____
Collected Revenue	_____

(c) For the purposes of (b) above:

1. Gross patient service revenues shall include charges for all patients receiving routine ancillary and ambulatory services during 1993, including those receiving charity care.

2. Excluded services as defined in N.J.A.C. 8:31B-4.61 to 4.67 were not included in the 1993 revenue cap and shall not be included in collected revenue. Separate detail shall be provided on the following services: skilled nursing facility, mobile intensive care unit, outpatient dialysis, excluded ambulatory services.

3. Current year payer allowances reflecting the difference between charges and paid amounts shall be displayed separately for each payer comprising more than five percent of gross revenue.

4. Uncompensated care is defined in N.J.A.C. 8:31B-4.38, and shall be reported without an offset for Medicaid disproportionate share payments. Bad debt shall be reported net of recoveries from bad debt and SOIL (Setoff of individual liability, pursuant to N.J.A.C. 8:31B-4.40 and N.J.A.C. 18:35-2).

5. Allowances for personnel health, medical denials, nursing home placement, prompt payment discounts and other administrative adjustments shall be calculated consistent with N.J.A.C. 8:31B-4.15.

6. Allowances exclude prior year over and undercollections. All third party retroactive payments or settlements shall also be excluded.

7. Funds related to the charity care, other uncompensated care, hospital relief fund and mental health subsidies shall not be included in these amounts. Subsidy funds shall not be reflected in the cap amounts.

(d) Hospitals shall submit the information for the year ended December 31, 1993 outlined in (b) above by May 31, 1994, in a format to be supplied by the Department, accompanied by an auditor's agreed upon procedures report. The auditor's report shall comment on classification of allowances and revenues based on the above definitions. The auditor shall trace and agree amounts to the general ledger. Hospitals shall also submit the information outlined in (b) above, in a format to be supplied by the Department, 60 days after the end of each of the first three quarters during 1993, for the purposes of monitoring. For the purposes of calculating compliance with the revenue cap, the Department will calculate a reasonable estimate of amounts needed to complete the calculation under (b) above if the required data are not submitted by this date or if data is submitted in other than the required format.

(e) The Department will conduct an audit of the items specified in subsection (b) for reasonableness, taking into account the hospital's experience in earlier years, billing information and other applicable data.

(f) If a hospital's collected revenue, as defined in (b) above, exceeds the 1993 revenue cap as approved by the Hospital Rate Setting Commission by more than one percent, the Department will calculate a penalty equal to the total excess. The percentage for each hospital is calculated by dividing the excess by the cap. A hospital which is assessed a penalty shall be afforded the opportunity to contest the penalty at a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 and 14:7-1 and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

New Rule, R.1993 d.362, effective July 19, 1993.
See: 25 N.J.R. 1660(a), 25 N.J.R. 3205(a).

Case Notes

Exception to Administrative Procedure Act's procedural requirements did not apply to Hospital Rate Setting Commission's rate adjustment cap. *St. Barnabas Medical Center v. New Jersey Hosp. Rate Setting Com'n*, 250 N.J.Super. 132, 593 A.2d 806 (A.D.1991).

Hospital Rate Setting Commission's cap on settlement of hospital rate appeals was rulemaking. *St. Barnabas Medical Center v. New Jersey Hosp. Rate Setting Com'n*, 250 N.J.Super. 132, 593 A.2d 806 (A.D.1991).

8:31B-3.71 (Reserved)

Amended by R.1988 d.25, effective January 4, 1988.
See: 19 N.J.R. 1147(a), 20 N.J.R. 82(a).

Added text to (a) "and indirect financial ... in N.J.A.C. 8:31B-3.24".
Amended by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Provision for volume variable reconciliation added.
Emergency amendment, R.1991 d.506, effective September 16, 1991 (expires November 15, 1991).
See: 23 N.J.R. 2881(a).

Reference to N.J.A.C. 8:31-3.65(b) added.
Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Reference to 3.65(b) added; (c) added.
Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
Section was "Reconciliation and adjustments".

Case Notes

Final reconciliation defined; necessary to insure that hospital's net collection revenue aligns with rate schedule, providing cost containment mandated by statute; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

8:31B-3.72 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.
See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added "financial reviews of 1979 actual costs" to (a)2ii.
Amended by R.1983 d.206, effective June 6, 1983.
See: 15 N.J.R. 471(a), 15 N.J.R. 920(a).

In (a)1., deleted old i.-ii. and added new 1.
Amended by R.1985 d.349, effective July 1, 1985.
See: 17 N.J.R. 872(a), 17 N.J.R. 1652(a).

(a)2iii through v added.

Amended by R.1991 d.158, effective March 18, 1991.
 See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
 Stylistic changes.
 Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 Revised (a)1 and (a)3.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Periodic adjustments".

Case Notes

Automatic adjustments made by Department of Health in final reconciliation; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

8:31B-3.73 (Reserved)

Amended by R.1983 d.200, effective June 6, 1983.
 See: 15 N.J.R. 201(a), 15 N.J.R. 920(b).
 In (a)1., added iii.
 Amended by R.1988 d.24, effective January 4, 1988.
 See: 19 N.J.R. 1145(a), 20 N.J.R. 77(a).
 Substantially amended.
 Amended by R.1988 d.25, effective January 4, 1988.
 See: 19 N.J.R. 1147(a), 20 N.J.R. 82(a).
 Added text in (a)2i. "from revenue centers ... in N.J.A.C. 8:31B-3.24".
 Amended by R.1989 d.387, effective July 17, 1989.
 See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).
 Specification to rate years through 1988 added at (a)1ii.
 Amended by R.1989 d.471, effective September 5, 1989.
 See: 21 N.J.R. 1606(b), 21 N.J.R. 2787(b).
 Added (a)5, concerning nonparticipating payers and discharges after January 1, 1989; and (a)6, concerning Medicare payments for rate years 1986, 1987 and 1988.
 Amended by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Provision for volume variable reconciliation and technology factor added; reconciliation provisions updated.
 Amended by R.1991 d.158, effective March 18, 1991.
 See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
 Stylistic changes.
 Amended by R.1991 d.213, effective April 15, 1991.
 See: 22 N.J.R. 3724(a), 23 N.J.R. 1176(a).
 Reconciliation to be based on the lower of the aggregate charges or approved revenue for the rate year.
 Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 23 N.J.R. 3442(a), 24 N.J.R. 425(a).
 Rate adjustment to occur only in year following rate year, as a percentage add-on; good faith efforts to collect Medicaid required.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Reconciliation: Hospitals".

Case Notes

Final reconciliation defined; necessary to insure that hospital's net collection revenue aligns with rate schedule, providing cost containment mandated by statute; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

8:31B-3.74 (Reserved)

Repealed by R.1993 d.593, effective November 5, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Reconciliation: Payers".

8:31B-3.75 (Reserved)

Amended by R.1982 d.427, effective December 6, 1982.
 See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).
 Added "50 percent during initial 12 months; 25 percent during second 12 months; and 20 percent in the third 12 months".
 Amended by R.1983 d.597, effective December 19, 1983.
 See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).
 (b)1: clarified determination of reasonable direct patient care costs.
 (b)2: deleted 50 percent and 25 percent discretionary subsidies concerning first and second 12-month periods.
 Amended by R.1984 d.531, effective November 19, 1984 (operative January 1, 1985).
 See: 16 N.J.R. 2321(b), 16 N.J.R. 3197(b).
 Section substantially amended.
 Amended by R.1990 d.462, effective September 17, 1990.
 See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).
 Final reconciliation settlement period to be determined by the Commission.
 Amended by R.1991 d.158, effective March 18, 1991.
 See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).
 Adjustments made in following rate year; elements of adjustment clarified in (b).
 Amended by R.1992 d.62, effective February 3, 1992.
 See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
 Rate adjustment to occur only in year following rate year, as a percentage add-on, including interest.
 Repealed by R.1993 d.593, effective November 15, 1993.
 See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).
 Section was "Schedule of Rates reconciliation".

Case Notes

Rates adjusted on basis of comparison between actual net revenue and allowable net revenue with interest; overcollection and undercollection definitions; reconciliation process not rulemaking by Commission; order modification proper. In re: 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J.Super. 79, 506 A.2d 1269 (App.Div.1986).

8:31B-3.76 Necessity and appropriateness of health care services

(a) P.L.1978, c.83 provides that reasonable payment may be made only for "appropriate and necessary health care services of high quality required by (each) hospital's mix of patients." In order to discharge this statutory obligation, two systems are required: The reimbursement system, payment by the case, establishes reasonable rates for patients who are correctly assigned to a Diagnosis Related Group (DRG). A utilization review organization system is required to ensure that the hospital services which are provided are appropriate, necessary, and of high quality.

(b) This section sets forth minimum qualification criteria for utilization review organizations, prescribes the qualification procedure, and establishes a method for financing organizations which qualify. The criteria are designed to delineate the respective roles of payment and review so as to capitalize on the strengths of each. In this way, the systems may complement one another to the greatest degree, thereby promoting "effectiveness and efficiency of the health care system as a whole." L.78, c.83, Section 11C.

(c) Once designated by the Department as a qualified Utilization Review Organization, the URO shall have access to only those hospital patient records for which it has direct review responsibility. The URO shall be required to main-

tain the confidentiality of the hospital and patient records. Access to this data will be allowed for the purpose of fulfilling review responsibility under these regulations.

(d) Nothing in this regulation shall be construed to supersede or conflict with any part of Title XIB of the Social Security Act (42 USC 1320c-1320c-20) or regulations adopted thereunder, nor with prevailing statutes or contracts affecting the business of insurance.

(e) Reporting: Minimum standards for uniform reporting by the Utilization Review Organization utilizing the UB-PS data shall be determined by the Department. Format and reporting timeframe will be reviewed with the Review Organizations.

Amended by R.1983 d.597, effective December 19, 1983.
See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

New (c) added, existing (c) made (d); (e) added.
Amended by R. 1985 d.551, effective November 4, 1985.
See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

(b) substantially amended.
Amended by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Utilization review organization system required in (a).

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

8:31B-3.77 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the text indicates otherwise.

“Active physicians” means Doctors of Medicine or Osteopathy holding unrestricted licenses and having current admissions privileges at a licensed hospital.

“Admission certification” means a review of the medical necessity and appropriateness of a patient’s admission to the hospital.

“Audit Principal Diagnoses and Procedures” means to examine and validate the assignment of principal diagnoses and/or procedures by physician(s) and medical record department.

“Appropriateness of level of care” means compliance with professionally developed criteria that determine whether the patient belongs in an acute hospital, a skilled nursing facility, an intermediate care facility, or none of those.

“Binding determinations” means those decisions of a utilization review organization which direct a type or level of payment, including no payment, by the appropriate payer.

“Carve-out” means a mechanism used to identify medically unnecessary days during a patient’s hospitalization which resulted from an avoidable delay. Such delays can be administrative (for example, O.R. scheduling delays) or physician related (for example, delay in responding to a consult request).

“Certification” means the process used by the Review Coordinator (R.C.) to indicate that an admission or continued stay is certified for payment purposes at given levels of care.

“Concurrent review” means a review of medical necessity and/or appropriateness conducted during a patient’s hospitalization, consisting of admission and continued stay certification.

“Continued stay review” means a review and determination of the medical necessity and appropriateness of continuation of the patient’s stay at a given level of care. Continued stay review may also include a detailed assessment of the quality of care being provided.

“Delegated” means authorization granted by a qualified utilization review organization to a hospital to conduct one or more review functions, subject to a finding of the hospital’s capability and willingness to accept such responsibility and submission of an acceptable plan for the review by the hospital.

1. “Full delegation” means complete delegation of both concurrent review and Quality Review Studies (QRS).

2. “Partial delegation” means authorization by the URO to a hospital to conduct a portion of the review. The remainder of review is provided by staff of the URO.

3. “Non-delegation” means the URO retains responsibility to perform all of the review activities in a hospital.

“Denial” means a formal decision by a URO or a delegated hospital committee that all or part of a patient’s stay is medically unnecessary and/or inappropriate, with consultation by physicians licensed to practice medicine in New Jersey (See Physician Advisor—Item Y).

“Denied days” means days which have been determined to be medically unnecessary.

“Diagnosis Related Groups (DRGs)” means a patient classification scheme in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications. Each DRG exhibits a consistent amount of resource consumption as measured by some unit (e.g., length of stay, dollars, etc.).

“Discharge planning” means advance preparations for placement of a patient at another level of care in the appropriate setting after hospital discharge.

"Focused review" means an application of sampling techniques such as an intensification of or an exemption from detailed review of certain groups of patients or common diagnoses where data indicate it is reasonable to do so.

1. Focus-in describes an intensified review of a specified category of patients, diagnoses, procedures, and/or physicians.
2. Focus-out describes specific categories of patients, diagnoses, procedures, and/or physicians who are exempt from concurrent review, diagnosis, procedures, and/or physicians.

"Grace days" means medically unnecessary or inappropriate days of hospitalization which payor may reimburse in order to facilitate administrative processes or to insure that the implementation of binding determinations does not have a punitive effect on patients or institutions.

"Inliers" means inpatient cases assigned to DRGs, as identified in N.J.A.C. 8:31B-5.3(c) having lengths of stay within the high and low trim points.

"Intensity of service" means the level of service that a patient receives in a hospital setting.

"Intermediate Care Facility (ICF)" means an institution which provides continuous or Intermittent nursing care to in-patients under the general direction of a professional registered nurse.

"Length of Stay" means the number of days that a patient is hospitalized.

1. "Certified length of stay" means the number of days which have been determined to be medically necessary at covered levels of care for payment purposes.

"Medical necessity" means compliance with professionally developed criteria and standards of care for determining that a patient warrants an acute hospital level of care for a given diagnosis and/or problem.

"Outliers" means patients who display atypical characteristics relative to other patients in a DRG (see N.J.A.C. 8:31B-3.38(c)2).

"Peer review organization" means an organization which is composed of or governed by active physicians, and other professionals where appropriate, who are representative of the active physicians in the area in which the review mechanism operates, which is organized in a manner that insures professional competence in the review of services.

"Physician Advisor (P.A.);" means a currently licensed physician who makes determinations and provides consultation on a referral basis to nonphysician reviewers in cooperation with the Attending Physician on the appropriateness, quality and/or necessity of an individual's admission to or continued stay in a hospital.

"Preadmission certification" means a form of health care review which occurs prior to a patient's admission to a hospital and consists of a determination of the medical necessity and appropriateness of a patient's elective admission to a hospital level of care.

"Profile" means a presentation of aggregated data in formats which displays patterns of health care services over a defined period of time.

"Quality assessment" means a retrospective medical record review program by the physician advisor to assess the quality of services rendered.

"Quality review study" means a retrospective, medical record review of the quality and/or utilization of health care services.

"Reconsideration" means a process which allows a patient, patient representative, or physician to request the URO to hold a formal hearing to reconsider an adverse determination.

"Review Coordinator (RC)" means a health care professional, usually a Registered Nurse, who assists physicians in performing chart review to determine if a hospital stay is medically necessary and if the services provided are appropriate.

"Retrospective review" means Medical Record Review performed after a patient has been discharged.

"Severity of illness" means the manifestation of disease or injury that clinically indicates the need for hospitalization.

"Utilization review plan" means a description of utilization review activities to be prepared by the URO and approved by DOH. The plan shall describe methodology for determining hospital delegated status; the criteria and description of the methodology for monitoring admission and discharge review; the criteria and description of the methodology to review the performance of delegated and nondelegated review and focus program.

"Principal diagnosis" means that condition established after study as being responsible for occasioning the admission of the patient to the hospital for care.

"Principal procedure" means that procedure most related to the principal diagnosis and performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication:

1. If only one procedure was performed, it is the principal;
2. If more than one procedure was performed, the principal procedure is one which was performed for definite treatment, rather than one performed for diagnostic

or exploratory purposes, or was necessary to take care of a complication;

3. If more than one procedure was performed for definite treatment, the principal procedure is that most related to the principal diagnosis.

“Skilled Nursing Facility (SNF)” means an institution which is primarily engaged in providing skilled nursing care and related services for inpatients who require medical supervision of their care or rehabilitation services on a daily basis.

“Trim points” means high and low length of stay cutoff points assigned to each DRG (see N.J.A.C. 8:31B-5.3). Cases falling outside trim points are classified as outliers.

“Utilization Review Organization (URO)” means a group of physicians within a designated geographical area who review the health care provided to patients in area hospitals. Physicians may be assisted by other health care professionals.

“Utilization review plan” means a description of utilization review activities to be prepared by the URO and approved by DOH. The plan shall describe methodology for determining hospital delegated status; the criteria and description of the methodology review; the criteria and description of the methodology to review the performance of delegated and nondelegated review and focus program.

As amended, R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

Substantially amended.

Amended by R. 1985 d.551, effective November 4, 1985.

See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Definitions “focus” and “outliers” substantially amended.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

References to typical and atypical cases and “Physical Advisor” deleted.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

8:31B-3.78 Criteria for qualification

(a) Applicability: Each inpatient in each hospital selected by the Commissioner pursuant to P.L.1978, c.83, Section 5b, must be subject to review by a qualified utilization review organization concerning the necessity and appropriateness of inpatient admission and continuing stay. The minimum set of activities required to so qualify are set forth below:

1. All cases: With respect to all cases, a qualifying utilization organization:
 - i. Shall certify the medical necessity of each admission;
 - ii. Shall certify the appropriateness of the level of care to be provided;

iii. May, with the approval of the Department, discharge the obligations of (a)i and ii above through an appropriate review system;

iv. Shall, with the advice and consent of the Department, institute such systems, which may include, but not be limited to, concurrent, retrospective and focused review, medical care evaluation studies and profile analyses, which best promote efficiency and effectiveness with respect to the health care delivery system, taken as a whole; provided, however, that nothing herein shall be construed as to involve the Department in supervising or regulating the private practice of medicine;

v. Pursuant to N.J.A.C. 8:31B-3.17(b), the Department having given adequate notice to the hospital, may perform a cursory or detailed on site review at the Department’s discretion of any hospital procedure deemed necessary to determine the effectiveness of the reimbursement system in effect.

vi. Shall consult with the Department which shall set common upper and lower trim points with respect to all patients; however, any modification of trim points by the Department during a rate period shall not effect the revenues to which any hospitals are entitled under determinations of the Commission. Adjustments to hospital’s revenue to compensate for changes in trim points shall be accomplished at final reconciliation, and interim adjustments may be effected through adjustments to hospitals’ Indirect Cost percentages, subject to Commission approval, as provided for in N.J.A.C. 8:31B-3.51 through 3.62;

vii. Shall provide for an appropriate mechanism by which to hear and adjudicate appeals by patients, payers, physicians, or the hospital concerning the determinations made pursuant to this subchapter. With respect to such review, the standards to be applied shall be consistent with the prevailing patterns of medical practice in the area or state, as appropriate;

viii. Shall further provide, through the same mechanism, for appeals by individual patients in exceptional cases of DRG assignments which, although technically correct, may produce grossly inequitable or excessive payments. To initiate an appeal, a letter of request from the patient shall be considered as authorization for the Department to review and assess any necessary information pertinent to the hospitalization or charges in question. Upon demonstration, by substantial evidence, that application of the DRG system would result in inequitable consequences for the patient, the qualified utilization review organization may direct that payment be based on an alternative to the DRG rate (for example, charges);

ix. Shall provide a second level of appeal. Party not satisfied with the decision on the first level appeal, may request an appeal to the second level through the appropriate Utilization Review Organization;

x. Shall insure that all binding determinations of medical necessity or appropriateness are made by qualified review personnel of an established peer review mechanism representative of physicians in the appropriate area of the State, as defined in N.J.A.C. 8:31B-3.77;

xi. Shall render a decision in any appeal within 30 working days from the date of receipt of the appeal by the qualified Utilization Review Organization (URO). The appellant, or his or her insurer, shall not be liable for payment to the hospital until a decision on the appeal has been made and communicated to the parties affected. A qualified URO shall not be deemed in receipt of an appeal if the hospital involved is more than one month delinquent in payment of the Commission approved rate to be paid to the URO by the hospital. Any amount not paid to the hospital because of its delinquency in payment to the URO, and the failure to hear an appeal shall not be recoverable by the hospital through bad debt or charity write-offs, but shall become a loss of revenue to the hospital.

(1) DRG Patient Appeal requests shall be submitted to the Department of Health for review within one year after issuance of the bill by the hospital. Any requests submitted thereafter will not be processed for appeal.

xii. Shall certify the necessity and appropriateness of the services, days, and where it is judged reasonable to do so, the items charged to such patients by the hospital;

xiii. Shall institute such system of concurrent review as may be necessary in order to assure the timely discharge, or placement to the most efficient, appropriate level of care, consistent with high quality; and

xiv. Shall, using a reasonable sampling technique, audit principal diagnosis and principal procedure, in order to assure that typical cases have been assigned to appropriate diagnosis related groups.

Amended by R.1983 d.597, effective December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

New (a)1v added, existing text amended and recodified; (a)lix(1) added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

References to typical and atypical cases deleted; process clarified.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

8:31B-3.79 Use of findings

(a) Findings shall be used in all cases as follows:

1. Denial of Payment: Unnecessary admissions: The qualifying utilization review organization shall direct the appropriate payor to deny payment concerning any admission for which medical necessity has not been certified; provided, however, that a payor may agree with any hospital to reimburse charges for a grace period, not to exceed three calendar days, after notification to the patient, hospital, physician, and payor, of denial of payment certification.

2. Adjustment of Payment shall be made as follows:

i. Continuing necessity: The qualifying utilization review organization shall prospectively direct the appropriate payor to deny charges for such items, services or days for which continuing medical necessity has not been certified; provided, however, that a payor may agree to reimburse any hospital for a grace period, not to exceed three calendar days, after notification of the patient, physician, payor and hospital of the denial of medical necessity for continuing stay.

ii. The following shall apply to a finding of an inappropriate level of care: Should the qualifying utilization review organization determine that, for a portion of the patient's length of stay, the level of care is appropriate to a skilled nursing facility and/or intermediate care facility level-of-care, and that a hospital has documented a good faith continuing effort to obtain placement of the patient to the appropriate level-of-care, a Skilled Nursing Facility (SNF) and/or Intermediate Care Facility (ICF) rate, calculated as follows, will become the basis for determination of reasonable Direct Patient Care Costs for that portion of the stay in an atypical case.

(1) Reimbursement for each eligible patient will be based upon a Statewide weighted average SNF or ICF per diem rate of Medicaid participating long-term care facilities, in effect as of January 1 of the rate year. Separate Statewide weighted average per diem rates will be calculated for both the Skilled (SNF) and Intermediate (ICF) levels of care patients as follows:

(2) Multiply the SNF payment rate, of each Medicaid long-term care facility, in effect as of January 1 of the rate year by the total Medicaid SNF patient days as reported on the most recent Medicaid cost report (12-month period). The Statewide Medicaid total SNF dollars are divided by the total Statewide Medicaid SNF days to arrive at a weighted average SNF per diem. The ICF per diem is calculated following the same steps using total Medicaid ICF days and costs. These SNF and ICF rates will be final for billing purposes and final reconciliation.

iii. The following shall apply to a finding of misassigned DRGs: The qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to make an appropriate adjustment to the

price per case where the DRG to which the patient is correctly assigned differs from the DRG on which payment was based. Similarly, the qualifying utilization review organization shall direct the hospital and the Uniform Bill Intermediary to classify cases as outpatients, to be billed as outpatients when there is a finding of medical necessity for items and services rendered, but no medical necessity for inpatient admission.

3. The following shall apply to apportionment of liability: Upon a prospective finding that certain days, services, or items will not be necessary, the qualifying review organization shall so advise the respective patient, attending physician, hospital, and payer. Once all involved parties have had due notice and have exhausted all appeals, under N.J.A.C. 8:31B-3.78(a)1vii, the utilization review organization may direct the hospital to assign financial liability for such unnecessary days, services, or items to the patient. Accordingly, except for any grace days which a payer may agree to reimburse pursuant to this section (N.J.A.C. 8:31B-3.79), liability for the appropriate price per case shall be fixed at the point in time at which the patient was eligible for discharge; and any further days or services shall, subject to prevailing contracts and statutes, be the sole liability of the patient to be reimbursed to the hospital at a rate, determined by the hospital, no greater than its charges for such days or services established in accordance with N.J.A.C. 8:31B-3.53 through 3.57. Revenues received by the hospital in accordance with this provision shall be treated as Expense Recoveries in accordance with N.J.A.C. 8:31B-4.62 through 4.67.

4. Reporting shall be accomplished as follows: The qualifying utilization review organization shall report all denials and adjustments to the hospital, the appropriate physician, and the payer in a timely manner. All denials and adjustments shall be compiled by diagnosis related group and by hospital, and reported to both the Commission and the Department on, at least, an annual basis. However, except for adjustments made in accordance with N.J.A.C. 8:31B-3.71 through 3.86, any adjustment in a hospital's budget, or in a standard for a Diagnosis Related Group or set of Diagnosis Related Groups shall be made only by the Commission, upon recommendation by the Commissioner through a change in the rate period or schedule of Rates, approved by the Health Care Administration Board (see N.J.A.C. 8:31B-3.87).

As amended, R.1982 d.427, eff. December 6, 1982.

See: 14 N.J.R. 737(a), 14 N.J.R. 1389(a).

Added per diem rate "in effect as of January 1 and July 1 of each year".

As amended, R.1983 d.597, eff. December 19, 1983.

See: 15 N.J.R. 1326(a), 15 N.J.R. 2163(a).

(b)2ii(2): last sentence added.

Amended by R.1985 d.359, effective July 15, 1985.

See: 17 N.J.R. 873(a), 17 N.J.R. 1761(a).

(b)2ii(2) deleted and new text added.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

References to typical and atypical cases deleted; provisions added for misassigned DRGs and apportionment of liability.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

8:31B-3.80 Qualification procedure

(a) Submission of plans:

1. Any payor, Professional Standards Review Organization, or other qualified entity may submit to the Commissioner, a plan reasonably designed to meet the criteria set forth in N.J.A.C. 8:31B-3.78.

2. A plan may be designed to cover all patients to be admitted by a hospital or group of hospitals, or an appropriate portion thereof, and, where appropriate, on a hospital specific basis, may provide for a form of delegated review in which the hospital performs certain review functions, with monitoring and oversight by the qualifying utilization review organization. Each plan shall be designed to meet the criteria set forth in N.J.A.C. 8:31B-3.78 in the most efficient manner and shall include a payment proposal.

i. Each plan shall contain a review protocol, a description of how review criteria are to be determined and employed, and a plan for focusing reviews;

ii. Each plan which includes provision for delegated reviews shall include a description of how the performance of review at delegated hospitals will be monitored, and of the procedures for awarding and suspending delegation;

iii. The payment proposal shall, at a minimum, itemize proposed cost by category of direct review costs, overhead costs, monitoring costs, physician compensation, and other.

(b) Department review and recommendation:

1. The Department shall review all such plans within 90 days of submission and certify those plans which, consistent with L. 78, c.83:

i. Can be reasonably expected to fully meet the criteria set forth in N.J.A.C. 8:31B-3.78;

ii. Are designed to provide the services required above in the most efficient manner; and

iii. Consistent with high quality medical care, can be expected to best promote effectiveness and efficiency with respect to the health care delivery system, taken as a whole.

2. Special consideration shall be given to organizations which submit joint plans providing for coverage of wide geographical areas. In order to promote effectiveness and efficiency with respect to the health care system, the Department shall seek to avoid the undue proliferation of plans. Where appropriate, the Department may approve more than one plan for a given hospital or region; however, it shall approve more than two plans for a given hospital only under extraordinary circumstances. In considering plans for certification, the Department shall give consideration to the views of hospitals in the areas involved.

3. The Department may approve an effective date for plan activity no later than 90 days after approval of a plan.

Law Review and Journal Commentaries

Administrative Law—Hospitals. Steven P. Bann, 137 N.J.L.J. No. 3, 70 (1994).

8:31B-3.81 Payment for utilization review services

(a) Proposal: The Commissioner shall propose to the Commission reasonable adjustments to the Schedule of Rates for all hospitals to which this subchapter is applicable, together with such terms and conditions as may promote efficiency and effectiveness with respect to the health care delivery system, taken as a whole. Consistent with the criteria set forth in N.J.A.C. 8:31B-3.78, such proposal, which shall be based on the Department's review, analysis, and findings as to the reasonableness of cost proposals under N.J.A.C. 8:31B-3.71 through 3.86 shall be broken into the components defined in N.J.A.C. 8:31B-3.71 through 3.86.

(b) Commission approval: Following a hearing pursuant to N.J.A.C. 8:31B-3.78, the Commission shall approve or modify, and direct an appropriate adjustment to the Schedule of Rates to which this provision applies. In accordance with N.J.A.C. 8:31B-3.87(a)3, each affected hospital shall implement the approved adjustment consistent with the payor selection procedure set forth in (c) below.

(c) Payor selection procedure:

1. Within 30 days of approval by the Commissioner of any plan in accordance with N.J.A.C. 8:31B-3.80 any payor may:

i. Subject to approval according to N.J.A.C. 8:31B-3.80, apply its own qualified utilization review organization and receive a full discount from the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b);

ii. Contract directly with a qualified utilization review organization and receive a full discount from the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b);

iii. Where delegated review has been approved, contract directly with the qualifying utilization review organization to monitor and assist delegated review conducted by hospitals, and receive an appropriate discount from the overhead and monitoring cost components of the adjustment approved pursuant to N.J.A.C. 8:31B-3.81(b); or

iv. Whenever a payor fails to select (c)1i, ii or iii above, it shall be deemed to have elected (c)1ii or iii above, whichever is appropriate, with the qualified utilization review organization responsible for reviewing the greatest proportion of cases in the hospital involved. In the case of (c)1iii above, the payor shall pay the full utilization review adjustment to the hospital, which shall be responsible for remitting the appropriate amount to the qualified utilization review organization on a timely basis.

2. Payors must notify the Department, hospitals, and all qualified utilization review organizations, of their election under (c)1 above in writing. They may change their elections at any time subject to 60 days written notice.

3. Any payor with total utilization among its subscribers or beneficiaries of fewer than 500 days per 1,000 enrollees in the prior calendar year may apply to the Commission for a full discount from the adjustment without exercising (c)1i, ii or iii above, or being subject to (c)1iv above.

8:31B-3.82 Performance standards for maintenance of qualification

Within one year after certification, and each subsequent year thereafter, each qualified utilization review organization shall submit, in a form and manner to be prescribed by the Commissioner, such information and data as may be required to adequately assess the performance of such organizations in accordance with N.J.A.C. 8:31B-3.78. Qualification may be terminated on a finding of inadequate performance.

8:31B-3.83 through 8:31B-3.86 (Reserved)

8:31B-3.87 (Reserved)

Repealed by R.1993 d.593, effective November 15, 1993. See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a). Section was "Summary report".

8:31B-3.88 through 8:31B-3.90 (Reserved)

SUBCHAPTER 4. FINANCIAL ELEMENTS AND REPORTING

Subchapter Historical Note

All provisions of this subchapter became effective October 17, 1979 as R.1979 d.407. See: 11 N.J.R. 329(a), 11 N.J.R. 550(a). Amend-

ments became effective October 16, 1980 as R.1980 d.453. See: 12 N.J.R. 516(a), 12 N.J.R. 645(a). Further amendments became effective January 9, 1981 as R.1981 d.10. See: 12 N.J.R. 643(d), 13 N.J.R. 92(a). This subchapter was scheduled to expire October 17, 1984. The Governor granted a waiver of the scheduled expiration date from October 17, 1984 to October 17, 1985. See: 16 N.J.R. 2733(a) (October 15, 1984 New Jersey Register). This subchapter was readopted pursuant to Executive Order 66(1978) effective October 15, 1985 with amendments effective November 4, 1985 as R.1985 d.550. See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a). See chapter and section levels for further amendments.

8:31B-4.1 Purpose

(a) The purpose of this subchapter is to provide the basis for a standardized system of reporting the financial elements to be used in conjunction with the Hospital Reporting of Uniform Bill-Patient Summaries regulation (N.J.A.C. 8:31B-2), the Financial Reporting and Monitoring regulation (N.J.A.C. 8:31B-3) and the Uniform Cost Reporting rule (N.J.A.C. 8:31A-5.5) for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187 and P.L. 1992, c.160.

(b) The Commissioner shall require each general acute care hospital to report cost, revenue and statistical information in accordance with the uniform system described in this subchapter. This information is critical and is required to support the Department's public health activities which include planning, licensing, providing information to consumers and other interested parties and monitoring hospital costs and revenues.

PART I. REPORTING PRINCIPLES AND CONCEPTS

8:31B-4.2 Functional versus responsibility reporting

(a) A prerequisite for the informed review of hospital data is good communication, i.e., a common understanding and use of terminology among all parties. Imperfect communication results when terms such as "hours", "dietary", "purchased services", etc. mean different things to different people. The objective in the design of this manual is to achieve uniform reporting of financial elements consistent with uniform definitions of functional cost and revenue centers, statistical data, patient data and the natural classifications of expenses, i.e., salaries, supplies.

(b) Expenses, revenues and other data reported in a manner consistent with the definitions included herein will provide a sound basis for the establishment of a uniform system of reporting. This manual, however, is not requiring that institutions adopt this functional reporting system for their internal management reports, so long as institutions maintain the ability to report data with reasonable accuracy in accordance with the functional definitions and expense and revenue classifications defined herein.

(c) A hospital should structure its accounts for the purpose of managing a sound cost-effective and financially viable organization. In many instances, principally due to various budgetary control objectives, this goal may be better achieved through recording of expenses and revenues on a responsibility basis. However, it is highly unlikely that expenses and revenues recorded on a responsibility basis can be reported "as is" on the prescribed uniformed functional basis. This will necessitate the recast of expenses, revenue and statistics per N.J.A.C. 8:31B-4. Various reporting schedules provide the hospital with the opportunity to insure that the financial data used to develop the financial elements of the current Cost Base, despite the recasts and allocations involved, are equivalent to the hospital's own audited financial statements. A working knowledge of the principles, concepts and definitions included herein, especially with regard to the inclusion of specific functions within reporting centers and of the natural classifications of expense, is necessary for a hospital's accurate compliance with these reporting requirements.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.3 Prescribed reporting principles

(a) The reporting principles and concepts described in this chapter have been drawn from existing systems wherever possible.

(b) Any reporting principles and concepts not specifically discussed in this manual should be reported according to Generally Accepted Accounting Principles as interpreted in the opinions of the American Institute of Certified Public Accountants (AICPA) and in the statements by the Financial Accounting Standards Board (FASB).

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.4 Accounting entity

A fundamental reporting concept is that of the accounting entity or unit. For reporting purposes, the hospital is an entity capable of buying, selling and taking other economic action, which are to be accounted for separately from the personal affairs of those responsible for the hospital's administration. The hospital itself is the primary unit for which the accounting records are maintained. Many departments of the hospital assume sufficient importance to require separate treatment as subordinate entities or units of accountability for planning and control purposes.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.5 Continuity of activity

Another basic reporting concept is that of continuity of activity, or the going concern. The assumption is that the hospital will continue to function indefinitely. It then becomes necessary to divide the life of the hospital into reporting periods, to determine revenues earned and expenses incurred during each period and to measure the amounts of assets and obligations at the end of each period.

8:31B-4.6 Reporting period

(a) The basic reporting period is the 12 consecutive calendar months utilized for Medicare.

(b) New hospitals beginning operations on any day other than January 1 must select an initial reporting period beginning on the first day of operation, through the last month preceding the hospital's fiscal year. For example, a hospital beginning operations August 15, 1979 would have an initial reporting period running from August 15, 1979 through December 31, 1979 if it were on a calendar year. Its next reporting period would then be January 1 to December 31.

(c) Each calendar year's Financial Elements Reporting Forms as defined in N.J.A.C. 8:31B-4.131 are due on May 31 of the following year. Each year's Audited Financial Statement is due on May 31 of the following year. Failure to meet these time frames will result in penalties as stated in N.J.A.C. 8:31B-3.3.

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(c) added.

Amended by R.1984 d.500, effective November 5, 1984.
See: 16 N.J.R. 2326(a), 16 N.J.R. 3019(b).

Financial report forms and Statement due date changed from April 30 and June 30 to May 31.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.7 Objective evidence

(a) Information produced by the accounting process should be based, to the extent possible, upon objectively determined facts. Transactions should be supported by properly executed documents such as charge slips, purchase orders, suppliers' invoices, cancelled checks, etc. Such documents serve as objective evidence of transactions and should be retained as a source of verification of the data in the accounting records.

(b) Certain determinations that enter into accounting records are based on estimates. Such estimates should be based on past experience modified by expected future considerations. Examples would include recognition of estimated provisions for bad debts and self-insurance funding and the reporting of other operating expenses separately from Costs Related to Patient Care. Items of Other Operating Expenses, if not directly classified by the hospital, if large in amount, must be identified through a cost study, and if small in amount, costs may be deemed equal to revenue and such costs apportioned among the appropriate natural classifications of expense based on the hospital's estimate or the classifications of the center where originating. Worksheets are provided along with Reporting Schedules to aid the hospital in making all appropriate reclassifications. All such reclassifications should be consistent with the concept of materiality, defined in N.J.A.C. 8:31B-4.11.

(c) Books, papers, records, or other data relevant to matters of hospital ownership, organization, and operation

must be maintained. The data must be maintained in an ongoing recordkeeping system which allows the data to be readily verified by qualified auditors.

8:31B-4.8 Conservatism

Conservatism is a quality of judgement to be exercised in evaluating the uncertainties and risks present in the hospital entity to assure that reasonable provisions are made for potential losses in the realization of recorded assets and in the settlement of actual and contingent liabilities. However, conservatism is not justification for excessively high or low estimates.

8:31B-4.9 Consistency

(a) Consistency refers to continued uniformity during a period and from one period to another in methods of accounting, mainly in valuation bases and methods of accrual, as reflected in the financial statements of an accounting entity. Consistency is very important to the development and analysis of trends on a year to year basis and as a means of forecasting. However, consistency does not require continued adherence to a suboptimal method or procedure. Any change of accounting procedure, consistent with the materiality principal, must be brought to the attention of the Department of Health by way of a cover letter which will accompany the hospital's Financial Elements Report to include both a description and analysis of reporting impact of such accounting procedure changes.

(b) As an example, the accounting principal of accrual reporting (see N.J.A.C. 8:31B-4.13) may cause some hospitals who currently account for vacation on a cash basis to incur a one time reporting of expenses related to vacation time earned by employees but not yet taken. Such one time costs must be included in a cover letter and the Financial Elements Report shall identify only those vacations costs accrued in the current reporting period.

(c) Any accounting and reporting changes due to subsequent revisions of this manual or the documents referred to herein will be reported in accordance with the instructions which accompany those revisions.

8:31B-4.10 Full disclosure

The concept of full disclosure requires that all significant data be clearly and completely reflected in accounting reports. If, for example, a hospital were to change its method of accounting for certain transactions, within the limitations of this manual, and if the change had a material effect on the reported financial position, or operating results, the nature of the change in method and its effect must be disclosed when reporting costs. No fact that would influence the decisions of management, the governing board, or other users of financial statements should be omitted from or concealed in accounting reports.

8:31B-4.11 Materiality

Materiality is an elusive concept with the dividing line between material and immaterial amounts subject to interpretation. It is clear, however, that an amount is material if its exclusion from the financial statements would cause misleading or incorrect conclusions to be drawn by users of the statements.

8:31B-4.12 Basis of valuation

(a) Historical cost is the basis used in accounting for the valuation of all assets and in recording all expenses (except fair market value in the case of donated non-cash goods and services). Historical cost, simply defined, is the amount of cash or cash equivalents given in exchange for properties or services at the time of acquisition. It is the basis for the valuation of assets and for the recording of most expenses. Cost ordinarily has been the basis of accounting for assets and expenses because it is a permanent and objective measurement that reflects the accountability of management for the utilization of hospital funds.

(b) Long term investments are to be reported at current market value as noted in N.J.A.C. 8:31B-4.17, with corresponding income or loss reported as realized or unrealized.

(c) Hospitals frequently acquire property, equipment, services and supplies by donation. The property, equipment, service and/or supply is considered donated when acquired without the hospital's making any payment for it in the form of cash, property or service. The property, equipment, service or supply should be valued at acquisition at the fair market value which is the price that the asset would cost by bona fide bargaining between well-informed buyers and sellers at the date of donation (regardless of date of receipt). The fair market value of donated services must be recorded when there is the equivalent of an employer-employee relationship and an objective basis for valuing such services. The value of services donated by organizations may be evidenced by a contractual relationship which may provide the basis for valuation. The amounts recorded are not to exceed those paid others for similar work.

(d) The value of donated goods or services of a type not consistent with the definition given are not included as operating expenses (e.g., donated services of individuals such as volunteers, students and trustees).

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.13 Accrual accounting

In order to provide the necessary completeness, accuracy and meaningfulness in reporting data, the accrual basis of accounting is required. Accrual accounting is the recognizing and recording of the effects of transactions and other events on the assets and liabilities of the hospital entity in the time periods in which they apply rather than when cash is received or paid.

8:31B-4.14 Matching of revenues and expenses

(a) Determination of net income for a reporting period requires measurements of revenue, revenue deductions, and expenses associated with the period. Hospital revenue must be recorded in the period in which it is earned; that is, in the time period during which the services are rendered to patients and a legal claim arises for the value of the services.

(b) Once the revenue determination is made, a measurement must be made of the amount of expense incurred in rendering the services on which the revenue determination was based. Unless there is such matching of revenue and expense, the reported gain or loss of a period is meaningless.

(c) It is important that revenue deductions be given reporting recognition in the same period that the related revenues are recorded, even though certain of these revenue deductions cannot be precisely determined until sometime after the end of the reporting period.

(d) Expenses and revenues are to be matched not only for the hospital as a whole, but also for each cost and revenue center. The cost (revenue) center is an accounting device for accumulating items of cost (revenue) that have common characteristics. A cost center may or may not be a department within the hospital. A cost center such as utilities is an example where the cost center would not be a department of the hospital. The costs of the functions and activities included in each cost center description (see N.J.A.C. 8:31B-4 Part vi) are to be included in the cost center. Revenue relative to such functions and activities must be included in the matching revenue center. For example, expenses related to Laboratory are included in the Laboratory cost center and related revenue is to be included in the Laboratory revenue center.

(e) Some hospitals record revenue on an all-inclusive rate basis (a rate based on type of accommodation regardless of the utilization of ancillary services). Utilization of an all-inclusive rate system results only in a modification of the patient billing and revenue accounting system. It does not eliminate the need to report expenses by proper cost center.

(f) Revenues are classified as either operating or non-operating according to the following definitions:

1. Operating revenues and expenses include those transactions which are a part of the normal day-to-day operation of the hospital. They include but are not limited to those operations involved in the performance of all patient care activities (i.e., Services Related to Patient Care, see N.J.A.C. 8:31B-4.32).

2. Non-operating revenues are defined to be all transactions of the hospital which are not part of the normal day-to-day activities. Non-operating revenues (or losses) are to be reported net of expenses incurred in the transaction (e.g., gain or sale of securities should be shown net of brokerage fees, donations net of solicitation expenses, and rental income net of rental expenses.) Included are:

- i. Gains or losses from investments and the operation of non-hospital related businesses usually run at a site separate from facilities utilized for Services Related to Patient Care;
- ii. Donations and fund raising activities;
- iii. Interfund transactions (see N.J.A.C. 8:31B-4.16(c)7).

8:31B-4.15 Revenues and deductions from revenue

(a) If a hospital receives less than its full charges for the services it renders, it shall report to the Department both the gross revenue and revenue "adjustments" resulting from failure to collect full charges for services provided. These revenue adjustments are called Deductions from Gross Revenue. The specific deductions required for reporting Revenue Related to Patient Care, as defined in N.J.A.C. 8:31B-4.32 are defined in (a)1 through 11 below. Any individual allowance must be reported in only one of the 10 deduction categories and three contra categories (although individual transactions may be distributed among several if appropriate):

1. Third party payor allowances: These adjustments represent the differences between full charges for services and the payment anticipated from major third party payors according to contractual agreements or government mandated payor differentials. These adjustments exclude any deductions made by any third party payor for any other allowances which are more appropriately categorized in one of the following classes of deductions from gross revenue.
2. Prompt payment discounts: These adjustments are the difference between charges and payments received due to the prompt payment of a bill.
3. Personnel health allowance: These deductions represent adjustments from charges for services rendered to employees of the hospital and their families under a formal self-insurance or coinsurance plan of the hospital.
4. Courtesy adjustments: These deductions represent adjustments from charges for services rendered to any individual other than employees of the hospital and not otherwise more appropriately categorized, including any patient accounts written off contrary to the hospital's formal policies relative to credit, bad debts and indigency care.
5. Other Administrative Adjustments: These deductions represent adjustments made by the hospital as a matter of policy because of immateriality. Examples of these types of adjustments would include insignificant balances not billed to the patient or third party payor because of late billing occurring after payment has been received.
6. Medical denials: These deductions represent amounts not due from patients or third party payors because of a ruling by appropriate utilization review or

certification processes which determine that the services rendered were not medically appropriate or necessary, but excluding medical denials classified as Nursing Home Placement.

7. Nursing home placement: These deductions represent amounts not due from patients or third party payors because of rulings by appropriate utilization review or certification processes which determine that the services rendered were not medically appropriate to an acute care setting for patients who were unable to be placed in a skilled nursing facility because of a lack of available beds.

8. Charity care: These deductions represent charges for patients determined to be eligible for charity care pursuant to N.J.A.C. 8:31B-4.37.

9. County government grants for the medically indigent; municipal government grants for the medically indigent; other grants for the medically indigent:

i. These three categories represent all amounts received from governmental or other agencies for the care of medically indigent patients.

10. Bad debt provision:

i. These deductions represent the hospital's estimate of the amount of charges for Services Related to Patient Care during the reporting period (not otherwise accounted for as a deduction from Gross Revenue Related to Patient Care) which will not be received, net of recoveries of previously written-off accounts. Collection agency expense should not be included as a deduction from revenue but rather should be reported as operating expense and Cost Related to Patient Care as defined in N.J.A.C. 8:31B-4.32 and 4.118;

ii. The bad debt provision explicitly excludes deductions for contractual allowances, indigent patients, courtesy care, medical denials, finance charges or other non-medical service costs such as late fees and patient convenience items, and nursing home placement medical denial cases. Estimates of the bad debts incurred for the reporting period are to be reconciled to actual bad debts incurred for the reporting period and reconciled in the next reporting period's bad debt provision.

11. Other operating gross revenue: This account represents the amount of billings for services normal to the day-to-day activities of the hospital (net of any items reported as expense recovery) for Services Not Related to Patient Care.

(b) It is important to select the most appropriate classification of each deduction and the hospital is advised to establish procedures which will govern the approval and classification of transactions which will be recorded as deduction from Gross Revenue.

Amended by R.1989 d.491, effective September 18, 1989.

See: 21 N.J.R. 1487(a), 21 N.J.R. 2991(b).

Added (a)4i, concerning Statewide add-on.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Exclusion of non-medical service costs from bad debt provision.

Amended by 1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.16 Fund accounting

(a) Many hospitals receive income, gifts, bequests and grants from donors, governmental or other sources external to the hospital that are restricted as to their use. When funds with externally imposed restrictions are received, they must be recorded in a separate fund. This would not preclude the pooling of assets by the hospital among its funds for investment purposes.

(b) Funds transferred to the Operating Fund from the Restricted Fund for board restricted activities must be recorded in the Unrestricted Fund as nonoperating revenue and as operating expense when expended. For reporting purposes the recording of transactions among and within the Unrestricted Fund and Restricted Funds are to be in accordance with the AICPA Hospital Audit Guide.

(c) Funds fall into four categories: Unrestricted Funds, Donor Restricted Plant and Equipment Fund, Specific Purpose Funds and Endowment Funds. The accounts within each fund are self-balancing, and each fund constitutes a separate subordinate accounting entity. This subsection outlines the conditions and events which require separate accountability within the established funds.

1. Unrestricted Funds are used to account for all monies not restricted by donors or grantors in accordance with the rules set forth in this section. Two funds are to be established for unrestricted funds:

i. Operating Fund is used to account for funds derived from ongoing patient care and related day-to-day activities of the hospital, except for the portions of such funds otherwise classified here.

ii. Board Designated Funds are unrestricted funds which have been designated for specific purposes by the hospitals governing board. The board retains the right to undesignate such funds. The amount of such board designated funds for capital replacement and renovation as well as the sources and applications of all Board Designated Funds shall be reported annually to the Department of Health per N.J.A.C. 8:31B-4.13.

2. Restricted Internally Generated Major Moveable Equipment Replacement Fund ("Equipment Fund") is a fund to be used to account for the portion of all Net Revenues Related to Patient Care for the leasing, depreciation or replacement of major moveable equipment.

i. Income from the investment on the fund's assets shall also be credited to this fund, net of any income taxes attributable to such income. Investments are to be reported at market value, and unrealized gains and losses are to be reported as income or loss each period.

ii. This fund shall only be debited for major moveable equipment leasing and capital expenditures for acquisition or capitalized reporting.

3. Restricted Internally Generated Plant Replacement and Major Renovation Fund ("Plant Fund") is used to account for the portion of all Net Revenues Related to Patient Care (specified as the Capital Facilities Allowance) for the acquisition, preservation, renovation and replacement of the "plant," (as defined in N.J.A.C. 8:31B-4.21), i.e., buildings, building components, fixed equipment, land and capitalized assets other than minor or major moveable equipment. It will also account for all capitalized "plant" expenditures plus all debt service payments on long term debt other than those that may be assigned to the "Equipment Fund." Income earned (losses incurred) on investments (at market value) of the Plant Fund, less any income taxes attributable to such income, is restricted to the same capital purposes as the fund principal.

4. Donor Restricted Plant and Equipment Fund: Resources restricted by donors for the acquisition or construction of plant assets or the reduction of related debt are to be accounted for in the Donor Restricted Plant and Equipment Fund.

i. Income earned on investments and any losses incurred, valuing securities as at market value, must be reflected as an addition/reduction to the Donor Restricted Plant and Equipment Fund Balance if so specified by the donor.

5. Specific Purpose Funds: Funds received which are restricted for a specific purpose must be accounted for in a Specific Purpose Fund. Revenue and Expense transactions resulting from these resources, not otherwise restricted by the donor(s), must be recorded as other Operating revenue and operating expenses per the appropriate cost center or classification in the period in which these transactions are incurred. (In some instances the transactions resulting from these resources will be recorded as non-operating revenue and expense.)

6. Endowment Funds: Funds classified as Endowment Funds include:

i. Pure endowment (principal is to remain intact in perpetuity).

ii. Term endowments (principal is available for use upon the passage of time or the occurrence of an event).

Amended by 1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Regulation valid including hospital's available philanthropic funds as working capital for initial rate fixing purposes; legislative intent. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

8:31B-4.17 Long-Term Security Investments

Long-Term Security Investments are to be valued at current market value. If acquired by donation, they are to be valued initially at the fair market value at the date of the gift. Changes in the market value of investments, both realized and unrealized, during a reporting period are to be reported as income or losses for that reporting period.

8:31B-4.18 Pooled investments

(a) Investments of various funds may be pooled by the hospital unless prohibited by law or the terms of a donation or grant. Gains/losses and investment income on pooled investments must be distributed to participating funds on a basis utilizing market value at the time of pooling.

(b) Each time an addition is made to the investment pool, a new distribution basis must be calculated. This is also true for any reductions to the pool. All capital gains and losses and investment income from the beginning of the accounting period up to the date of the addition or reduction must be determined and distributed on the basis of account balances prior to the addition. Any capital gains and losses and investment income subsequent to an addition or reduction must be distributed on the new basis until another addition or reduction is made.

8:31B-4.19 Inventories

(a) Inventories reflect the cost of unused hospital supplies. Any generally accepted cost method (e.g., FIFO, LIFO, Average, etc.) may be used as long as it is consistent with that of the preceding accounting period. Cost of inventories based on the last invoice price is not an acceptable method for determining such costs.

(b) Inventory accounting record systems are required, consistent with the method of the inventory valuation employed. Physical valuations must be made at least once a year and the accounting records adjusted to such valuation when appropriate.

(c) Inventory activity records must be maintained for all inventories that are distributed and used by more than one cost center in the hospital. It is recommended that a formal requisition system be used for this purpose. In all cases, the cost of non-billable supplies used during the period must be distributed to the user cost center, preferably on a monthly basis.

8:31B-4.20 Accounting for minor moveable equipment

(a) Minor moveable equipment includes such items as waste baskets, bed pans, silverware, mops, buckets, etc. The general characteristics of this equipment are:

1. In general, no fixed location and subject to use by various departments within a hospital;
2. Comparatively small in size and unit cost;
3. Generally, a useful life of less than three years.

(b) There are three ways in which the cost of minor moveable equipment may be recorded:

1. The original cost of this equipment may be capitalized and not depreciated. Any replacements of or additions to this base stock would be charged to operating expense.
2. The original investment in this equipment may be capitalized and written off over three years. All subsequent purchases would be written off over three years.
3. All purchases of minor equipment may be capitalized and depreciated over their estimated useful lives.

(c) Once a hospital has elected one of these methods, that method must be used consistently thereafter.

8:31B-4.21 Accounting for capital facilities cost

(a) Capital Facilities include owned or leased land, land improvements, buildings, fixed equipment, leasehold improvements, major moveable equipment and related debt service requirements.

(b) Land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the hospital).

(c) Buildings include the basic walled structure or shell of a hospital and additions thereto.

(d) Fixed Equipment and Building Components include roofs and attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:

1. Affixed to building and not subject to transfer of movement;
2. Used for general purpose rather than for specific department functions.

(e) Leasehold improvements include betterments and additions made by the tenant to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

(f) Major moveable equipment is that equipment which usually has a relatively fixed location in the building, but is capable of being moved, generally has a specific function related to cost center functions, and has a life expectancy of at least three years.

(g) Debt service requirements are principal and interest on buildings, fixed equipment, land, land improvements, leasehold improvements, and capitalized renovations as well as escrow payments in addition to principal and interest required under the terms of a mortgage but not including operating expenses as defined by GAAP and lease payments required for leased assets capitalized in accordance with the GAAP.

1. **Classification of Fixed Asset Expenditures:** Assets and related liabilities as defined above must be recorded in Unrestricted Funds, since segregation in a separate fund would imply the existence of restrictions on the use of the asset. This includes costs of construction in progress.

2. **Basis of Valuation:** Property, Plant, and Equipment, whether owned or leased, must be reported on the basis of cost. Cost shall be defined as historical cost or fair market value at the date of bequest in the case of donated property.

i. Interest and capitalization on site preparation costs associated with borrowings for, or purchase of, major moveable equipment are included with the cost of the equipment.

3. **Accounting Control:** To maintain accounting control over capital assets of the hospital, a plant asset ledger should be maintained as part of a hospital's general accounting records. Some items of equipment should be treated as individual units within the plant ledger when their individuality and unit cost justify such treatment. Other items of equipment, if they are similar and are used in a single cost center, may be grouped together and treated in a single unit within the ledger so long as such items are depreciated in a manner equivalent in result to individually depreciating each item.

4. **Capitalization Policy:**

i. If an asset has, at the time of its acquisition, an estimated useful life of greater than three years and a historical cost in excess of \$300.00, its cost must be capitalized.

ii. If an asset does not meet the above criteria, its cost must be recorded as an expense in the year it is acquired. Alterations and renovations which are in excess of \$300.00 and which extend the life of the asset renovated a minimum of three years must be capitalized. Alterations and renovations that do not meet the above criteria are to be reported as operating expense under repair and maintenance costs in the current period.

iii. This shall be the required Capitalization Policy for the reporting assets acquired (and renovations per (g)6 below), subsequent to a hospital's first Commission approved Schedule of Rates. Assets acquired prior to this date are to be reported in accordance with GAAP.

5. **Interest Expense During Period of Construction:** Frequently hospitals borrow funds to construct new facilities or modernize and expand existing facilities. Interest costs incurred during the period of construction must be capitalized as part of the cost of the construction for reporting purposes. The period of construction is considered to extend to the date the constructed asset is put into use. When proceeds from a construction loan are invested and income is derived from such investments during the construction period, the amount of interest expense to be capitalized must be reduced by the amount of such income.

6. **Depreciation Policies:**

i. Depreciation allowances generated from assets used in the hospital's operations are to be reported as an operating expense in the Unrestricted Funds. Straight-line depreciation must be reported for all assets, with replacement cost provisions (subject to appropriate planning requirements) and debt service requirements for capital assets utilized for Services Related to Patient Care provided for in N.J.A.C. 8:31B-4.42.

ii. The estimated useful life of a depreciable asset is its normal operating or service life in terms of utility to the hospital. Some factors to be considered in determining useful life include normal wear and tear, obsolescence due to reasonably expected technological advances, climatic or local conditions and the hospital's policy of repair and replacement. In selecting a proper useful life for computing depreciation, hospitals must utilize Asset Depreciation Range or the most recent approved or American Hospital Association useful life guidelines at the time of the cost filing (i.e., 1978 Revisions). Costs of alterations, renovations, etc. over \$300.00 which extend the life of an asset at least three years are to be added to the remaining book value of the altered or renovated asset and depreciated straight-line over the remaining useful life of the asset (as defined in N.J.A.C. 8:31B-4.3).

iii. The preferred depreciation policy for reporting purposes is for hospitals to record one-half year depreciation in the first year an asset is acquired and one-half year depreciation in the last year of the asset's useful life, but that buildings or major renovations be depreciated based on the month first put into use. However, any depreciation policy consistent with GAAP is acceptable.

iv. When an asset is retired, the difference between its book value (historical acquisition cost plus capitalized renovations less accumulated depreciation) and its net salvage value shall be recorded as an adjustment to that year's depreciation expense in the cost center or classification to which the asset was assigned.

v. When Major Moveable Equipment has reached its useful life, but remains in use, its historical cost and accumulated depreciation may be retained in the accounting records by department. However, hospitals must be able to report fully depreciated assets separately from those which are not fully depreciated.

7. **Debt Financing for Plant Replacement, Renovation and Expansion purposes:**

i. Debt financing for capital facilities may take many forms. Under the terms of most debt financing agreements the debtor is required to perform or is prohibited from performing certain acts. In many instances, debt financing gives rise to special accounting treatment because of discounts and premiums on bond issues, financing charges, formal restrictions on debt proceeds, and sinking and other required funds.

(1) Discounts and Premiums on Bond Issues: Discounts and premiums arising from the issue of bonds are to be amortized over the life of the related issue(s).

(2) Financing Charges: Costs of obtaining debt financing other than discounts (e.g., legal fees, underwriting fees, special accounts costs) are to be reported as deferred costs and amortized over the life of the related debt.

(3) Reporting of Debt Proceeds: Debt agreements for financing plant replacement and expansion programs may or may not require formal segregation of debt proceeds prior to their use. Proceeds which are not required to be formally segregated prior to their use are to be reported as other noncurrent assets in the Unrestricted Fund.

8. Sinking and Other Required Funds:

i. These funds are usually established to comply with loan provisions whereby specific deposits are to be used to insure that adequate funds are available to meet future payments of:

(1) Interest and principal (retirement of indebtedness funds); or

(2) Property insurance, related taxes, repairs and maintenance costs, equipment replacement (escrow funds).

ii. Funds of this nature may also be required to be held by trustees outside the hospital. Income generated from the investment of such funds may be immediately available to the hospital or such income may be held by the trustee for some future designated purpose.

iii. All internally generating sinking and other required funds will be accounted for in the following manner:

(1) All fund assets, unless the hospital relinquishes control of the fund through a trustee arrangement, must be recorded in the Restricted Internally Generated Plant Replacement Fund as a long-term investment. Payments to a trustee for sinking fund purposes should be recorded as reductions in the associated long-term debt.

(2) All income generated from the investment of such funds, except as excluded in (g.8i-iii) above, must be recorded as non-operating revenue in this fund, except as required under, "Interest Expense during Period of Construction," (see N.J.A.C. 8:31B-4.21). Income generated from funds under covenant agreement may be accounted for as an addition to the appropriate restricted fund balance account.

9. Early Debt Retirement:

i. Many bond contracts provide for the calling of any portion or all of the issue at the option of the issuer at a stated value usually above par, for the purpose of enabling the organization to reduce its indebtedness before maturity as occasion arises, or to take advantage of opportunities to borrow on more favorable terms. Bonds are often retired piecemeal through sinking fund operations.

ii. Costs incidental to the recall of bonds before their date of maturity are considered debt cancellation costs. Such costs include bond recall penalties, unamortized bond discounts and expenses, legal and accounting fees, etc. These costs must be reduced by any unamortized bond premiums and recorded in the Unrestricted Fund in accordance with Generally Accepted Accounting Principles.

(h) Any changes in debt financing shall be reported to the Commissioner as they occur.

Amended by R.1985 d.550, effective November 4, 1985.

See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

(g) "escrow" substituted for "escroll".

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.22 Timing difference

Timing differences result when accounting policies and practices used in an organization's accounting differ from those used for reporting operations to governmental units collecting taxes or to outside agencies establishing or making payments based upon the reported operations. These differences are to be reported on the hospital's records when they arise in accordance with relevant AICPA policies. For the reporting of deferred income tax refer to—Income Tax Allocation—Accounting Principles Board Opinions Nos. 11, 23, and 34.

8:31B-4.23 Reporting of pledges

All pledges, less a provision for amounts estimated to be uncollectable, are to be included in the hospital's financial reports. If unrestricted they are to be reported as non-operating revenue in the Unrestricted Fund in the period the pledge is made. If part of the pledge is to be applied during some future period, that part is to be reported in the period the pledge is received as deferred revenue. If restricted, they are to be reported as an addition to the appropriate restricted fund balance. See AICPA, Hospital Audit Guide.¹

¹ American Institute of Certified Public Accountants, 1211 Avenue of the Americas, New York, NY 10036.

8:31B-4.24 Self insurance

(a) Self insurance by a hospital for potential losses due to unemployment, and workmen's compensation claims but excluding self insurance for employee health care to be provided by the hospital asserted or otherwise, places all or part of the risk of such losses on the hospital rather than passing all or part of such losses to a third party. Where this method of insuring is used by the hospital, the payments into the fund or pool (if one is maintained) or payments on actual losses incurred are to be considered as insurance expense.

(b) It is required that where self insurance for other than those items listed above is elected to be used by a facility, the method should conform with the following:

1. **Self-Insurance Fund:** The hospital or pool establishes a fund with a recognized independent fiduciary such as a bank or a trust company. The hospital or pool and fiduciary enter into a written agreement which includes all of the following elements:

i. **General Legal Responsibility:** The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.

ii. **Control of Fund:** The fiduciary must have legal title to the fund and be responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control. Thus, the home office of a chain organization or a religious order of which the hospital is an affiliate cannot be the fiduciary. In addition, investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund; notwithstanding this, loans by the fiduciary from the fund to the hospital or persons related to the hospital are not permitted.

iii. **Payments by Fiduciary:** The agreement must provide that withdrawals must be for malpractice and comprehensive general patient liability losses only and those expenses listed in (b)4 below. Any rebates, dividends, etc., to the hospital from the fund will be used to reduce allowable cost.

iv. **Reporting:** The agreement must require that a financial statement be forwarded to the hospital or pool members by the fiduciary no later than 60 days after the end of each annual insurance reporting period. This statement must show the balance in the fund at the beginning of the period, current period contributions, and amount and nature of final payments, including a separate accounting for claims management, legal expenses, claims paid, etc., and the fund balance. This report and fiduciary's records must be available for review and audit.

v. **Income Earned:** The agreement must provide that any income earned by the fund less any income taxes attributable to such income, must become part of the Fund and must be used in establishing adequate fund levels.

2. **Soundness of the Fund:**

i. The hospital receives and retains an annual certified statement from an independent actuary, insurance company, or broker that has actuarial personnel experienced in the field of medical malpractice and general liability insurance. To be independent, there must not be any financial ownership or control, either directly or indirectly in the hospital.

ii. The actuary, insurance company, or broker shall determine the amount necessary to be paid into the fund. The fund should include reserves for losses based on accepted actuarial techniques customarily employed by the casualty insurance industry and expenses related to the self-insurance fund as specified in (b)4 below. The actuary, insurance company, or broker shall also provide for an estimate of the amounts to be in excess of what is reasonably needed to support anticipated disbursements from the fund.

iii. The actuary, insurance company, or broker must state the actuarial basis and the coverage period used in establishing reserve levels. Reserves will not be recognized as allowable costs for losses specifically denied herein. Thus, reserve payments will not be recognized for items such as:

(1) Losses in excess of the greater of 10 percent of a hospital's net worth or \$100,000 where a hospital elects to pay losses directly in lieu of establishing a funded self-insurance fund;

(2) Losses in excess of coverage levels which do not reflect the decisions of prudent management;

(3) Losses in excess of coverage for events that occurred prior to a hospital's participation under the Commission.

iv. The actuary, insurance company, or broker must provide its workpapers upon request.

3. **Claims Management and Risk Management Program:** A hospital or pool has an ongoing claims process and risk management program. The hospital or pool must demonstrate that it has an ongoing claims process to determine whether malpractice and comprehensive general patient liability exists, its cause, and the cost of claims. A hospital or pool may either utilize its qualified personnel or an independent contractor, such as an insurance company, to adjust claims. In addition, a hospital or pool must obtain adequate legal assistance in carrying out its claims process. Each hospital must also have an adequate risk management program to examine the cause of losses and to take action to reduce the frequency and severity of them. Such risk management program has the essential characteristics of programs required by insurers which currently insure providers for these risks. Therefore, a hospital must have an ongoing safety program, professional and employee training programs, etc., to minimize the frequency and severity of malpractice and comprehensive general patient liability incidents.

4. Expenses Related to Losses Paid Out of Self-Insurance Fund: The following expenses will be considered costs attributable to a self-insurance fund established by a hospital or pool: expenses of establishing the fund or pool, expenses for administering the claims management program, expenses involved with maintenance of the fund by the fiduciary, legal expenses, actuarial expenses, excess insurance coverage (if purchased by the fiduciary or pool), risk management (if performed by the fiduciary or pool), to the extent that such expenses are related to the hospital's self-insurance program. All other expenses will not be considered costs attributable to the fund, but should be included in provider administrative and general costs in the year incurred.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.25 Related organizations

(a) Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. Such organizations are independent if they are so characterized by their own charter, by-laws, tax-exempt status and governing board or a sufficient combination of these characteristics to demonstrate their independent existence from the hospital. The financial reporting of these organizations should be separate from or combined with reports of the hospitals in accordance with the AICPA's Hospital Audit Guide, as amended and supplemented, available from the AICPA Order Department, P.O. Box 2209, Jersey City, N.J. 07303.

(b) A hospital itself may be a subsidiary to or under the control of a large organization such as a university, governmental entity or parent corporation. It is typical in such situations for hospitals to receive services from these related organizations. Examples of services received are administration, purchasing, general accounting and menu planning. In addition, related organizations lease property, plant and equipment to hospitals as well as paying for various other items such as insurance. The related organization then usually charges for the service either directly or through a management fee. To be included as Costs Related to Patient Care all such charges must be similar to those which would have been charged if the transacting organizations were not related. The direct charges must be recorded in the appropriate cost centers as billed, and the management fee must be distributed to the functional centers where services are provided. The hospital shall maintain documentation of the actual management service for which a management fee is recorded.

(c) Disclosure of information by hospitals dealing with related firm(s):

1. For the purpose of insuring prudent buying, hospitals will report the existence of a related organization and each type of service provided, to the Department, if the total transactions amount to greater than \$10,000 per year.

2. Hospitals may be related to one or more separate organizations if:

- i. The hospital controls through contracts or other legal documents the authority to direct the separate organization's management or policies;
- ii. The separate organization controls through contracts or other legal documents the authority to direct the hospital's management or policies;
- iii. The hospital is for all practical purposes the primary beneficiary of the separate organization.

(d) At the Department's request relevant information reported to the Department may include:

1. The nature of the legal relationship between the hospital and the related firm(s).
2. Frequency of business transactions between the hospital and the firm(s); and
3. Purchase or lease contractual arrangements between the hospital and firms;
4. The amount of money involved; and
5. The financial statements of all related organizations.

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(c) and (d) added.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.26 through 8:31B-4.30 (Reserved)

PART II. FINANCIAL ELEMENTS

8:31B-4.31 Financial elements generally

The financial elements shall include the cost of the following, as defined in regulations proposed by the Commissioner and approved by the board: direct patient care principal and interest payments; paid taxes, excluding income taxes; education, research and training programs, not otherwise paid for by the State; the provision of health care services to individuals unable to pay them for reasons of indigency; bad debts, provided adequate recovery procedures are followed; preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements; reasonable working capital ... and where applicable and appropriate, reasonable return on investment where a hospital is operating efficiently and effectively.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.32 Services related to patient care

(a) Services related to Patient Care include Direct Patient Care; Paid Taxes excluding Income Taxes; and Edu-

cational, Research and Training Programs as further defined in N.J.A.C. 8:31B-4.33-4.35.

(b) Services Related to Patient Care include Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services as defined in N.J.A.C. 8:31B-4, Part V. Costs Related to Patient Care include salaries and wages, physician compensation, employee fringe benefits, medical and surgical supplies, drugs, non-medical and non-surgical supplies, purchased services and other direct expenses (i.e., the Natural Classifications of Expense; see N.J.A.C. 8:31B-4, Part III.) and major moveable equipment costs as determined in accordance with N.J.A.C. 8:31B-4.13 through 4.25 and N.J.A.C. 8:31B-4.42 and reported separately in N.J.A.C. 8:31B-4.131. Revenue Related to Patient Care includes charges and monies received from patients and third party payors for Routine Services, Ambulatory Services, and Ancillary Services. Costs and Revenue Related to Patient Care are to be reported per N.J.A.C. 8:31B-4.131. All cost and revenues of the reporting period not included in the definition Services Related to Patient Care (as above and in N.J.A.C. 8:31B-4, Part V) are to be reported separately as other operating and non-operating costs and revenues per N.J.A.C. 8:31B-4, Part IV and 4.131 for transactions affecting the hospital's unrestricted fund.

(c) All non-physician services and supplies provided to hospital inpatients, whether provided directly by the hospital or by a vendor, will be considered services and costs related to patient care, and are, therefore, financial elements.

(d) The Commissioner shall issue a public report on reimbursement for services purchased from vendors that are in violation of State certificate of need regulation.

Amended by R.1984 d.124, effective March 26, 1984, originally adopted as an emergency rule R.1984 d.26 effective January 24, 1984.

See: 16 N.J.R. 252(a), 16 N.J.R. 893(b).

Added (c) and (d).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

In determining how to allocate reduction in Medicare payments, Hospital Rate Setting Commission was required to consider Health Care Facilities Planning Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's reduction in Medicare payments was administrative rule. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission's process to allocate reduction of Medicare payments violated Administrative Procedure Act. *New Jersey Hosp. Ass'n v. New Jersey State Dept. of Health*, 227 N.J.Super. 557, 548 A.2d 211 (A.D.1988).

Hospital Rate Setting Commission erred in refusing to allow hospital to recalculate number of full-time equivalent residents and residents' salaries based on accepted standard. *St. Barnabas Medical Center v. New Jersey Hospital Rate Setting Commission*, 214 N.J.Super. 599, 520 A.2d 805 (App.Div.1987).

Regulation prohibits reimbursement for in-patient services furnished by providers failing to obtain a certificate of need; rebundling of bills for services provides for Commission review of charges. *Radiological Society of New Jersey v. New Jersey State Dept. of Health*, 208 N.J.Super. 548, 506 A.2d 755, (App.Div.1986), certification denied 104 N.J. 444, 517 A.2d 434.

8:31B-4.33 Direct patient care

Direct Patient Care is the provision by a hospital of medically necessary and appropriate health care services.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.34 Paid taxes

Taxes are monies paid to a governmental unit for conducting business related to direct patient care within its jurisdiction. Taxes related to financing of operations through the issuance of bonds, property transfers, issuance or transfers of stocks, and the like, are not classified as taxes; rather, they are to be amortized or depreciated with the cost of the security or asset. Sales and real estate taxes paid by a hospital in the provision of Services Related to Patient Care are to be included as Paid Taxes. All sales and real estate taxes for Services Related to Patient Care are to be reported in the General Administrative Services cost center and also reported separately from other classification of expense. Employment related taxes, such as FICA, Unemployment Compensation, and Worker's Compensation, are to be classified as employee fringe benefits for all employees, including hospital based physicians. Monies received by a hospital which chooses to self-insure in lieu of payments of Unemployment Compensation taxes and the associated administrative costs of such a self insurance program are included as financial elements and classified as employee fringe benefits, if such monies are reasonably related to the hospital's unemployment compensation experience.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Stylistic changes.

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.35 Educational, research and training program

(a) Educational program costs are the costs incurred by a hospital in the provision of a formally organized, planned program of study in a health service profession approved by an organization which recognizes the professional stature of health services education programs at the national level, net of any grants, tuition, and/or donations received for this purpose. To the extent that approved residencies for primary care physicians require training in ambulatory care facilities associated with a hospital, such reasonable expenses are included. Costs incurred by a hospital for direct patient care services rendered by medical, nursing, or allied health school personnel through an approved program in the hospital are financial elements provided that such costs would be included as financial elements if directly incurred by the hospital rather than under such arrangements. If not salaried or paid a stipend by the hospital, students are not to be considered as functioning in an employee capacity and thus no dollar amount should be imputed and reported for their services.

(b) Research program costs are those costs incurred by a hospital in systematic, intensive study directed toward a better scientific knowledge of the provision of health care services in a program of the National Institutes of Health or other program approved by the Commission. Specific purpose grants or other funds received to offset the costs of such programs from the Federal government, New Jersey State government, New Jersey Heart Association, or other governmental or charitable organizations sponsoring such programs are applied to offset Costs Related to Patient Care per N.J.A.C. 8:31B-4, Part IV of this manual.

(c) Training program costs are the costs of providing to employees orientation or other health care related training, including inservice and on-the-job training, primarily designed to benefit the hospital by helping employees better perform their assigned tasks. The costs of providing such training are classified as administrative expense. Costs of training and/or educational programs which primarily benefit the employee (e.g. tuition reimbursement programs) rather than the hospital are classified as employee fringe benefits and are to be reported as such in the appropriate cost centers.

8:31B-4.36 (Reserved)

8:31B-4.37 Charity care and reduced charge charity care for indigent patients

(a) Hospitals shall provide the following notice of availability of charity care, and shall post the notice, in addition to any notices required under Federal law, as follows:

1. The Department shall provide notices in English and Spanish about the availability of charity care and reduced charge charity care. The facility shall post these notices in appropriate areas of the facility, including but not limited to, the admissions area, the business office, outpatient clinic areas, and the emergency room. If the usual language of the households of 10 percent or more of the population in the service area of the facility, according to the most recent figures published by the Bureau of Census, is other than English or Spanish, the facility shall notify the Department who shall translate the notice into that language and supply the posted notice to the facility. The facility shall then also post the translated notice.

2. The facility shall provide individual written notice, in English and Spanish, of the availability of charity care and reduced charge charity care under these rules to each person who seeks services in the facility on behalf of himself or another, and to the legally responsible parent, spouse or guardian, if any, of the person seeking services. This notice shall:

i. State that the facility can request payment from the Uncompensated Care Trust Fund if it provides care without charge or below charges to people who meet the eligibility requirements of these rules.

ii. Set forth the criteria for determining eligibility for charity care and reduced charge charity care under these rules.

iii. State the location in the facility where anyone seeking a determination of eligibility for charity care and reduced charge charity care may make such a request.

iv. State that the facility will make a written determination of whether the person is eligible for charity care or reduced charge charity care as soon as possible, but no more than five working days from the time of the submission of a completed application with all required documentation. If the request does not include sufficient documentation to make such a determination, the request shall be denied. If the request is denied for lack of documentation, the applicant will be allowed to present additional documentation.

v. State that an applicant found ineligible may reapply at a future time when the applicant presents him or herself for services and believes his or her financial circumstances have changed, making him or her eligible for charity care or reduced charge charity care.

vi. State that charity care and reduced charge charity care is available only for medically necessary care.

3. The facility shall provide the individual with written notice of the availability of charity care or reduced charge charity care before providing services, except where the emergency nature of the services provided makes prior notice impractical. If this exception applies, the facility shall provide the written notice to the patient or responsible party as soon as practical, but no later than when first presenting a bill for services.

4. The facility shall make reasonable efforts to communicate the contents of the posted notice and the individual written notice to persons who it has reason to believe cannot read the notices.

(b) Income eligibility criteria for identifying charity care patients are as follows:

1. The provisions of 42 U.S.C. 9902(2), the poverty income guidelines revised annually by the United States Department of Health and Human Services, are hereby incorporated by reference. (For further information on the poverty income guidelines, contact Joan Turek-Brezina, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C. 20201, telephone 202-245-6141.) A person is eligible for charity care or reduced charge charity care if he or she falls into one of the following categories:

i. A person whose individual or, if applicable, family income, as determined by reference to (b)2 below, is less than or equal to 150 percent of the HHS Income Poverty Guidelines as adopted by the Department shall

be eligible for charity care for necessary health services without cost.

ii. A person whose individual or, if applicable, family income, as determined by reference to (b)2 below, is greater than 150 percent of the HHS Income Poverty Guidelines as adopted by the Department but not more than 250 percent of these guidelines shall be eligible for charity care for necessary health services at a reduced rate as prescribed by (b)3 below.

2. A person's income, for purposes of determining eligibility for charity care or reduced charge charity care, shall be the lesser of the following:

i. The actual gross income of the individual or, if applicable, the family, for the 12 months preceding the services.

ii. Four times the actual gross income of the individual or, if applicable, the family, for the three months preceding the services.

3. A person who is eligible for reduced charge health services shall be charged a percentage of the normal charge for health services after any applicable third party has paid; that percentage shall be calculated by the following:

i. Income as a Percentage of HHS Income Poverty Guideline as adopted by the Department		Percentage of Charges Paid by Patient
From	To	
150	175	20
175	200	40
200	225	60
225	250	80

ii. If the percentage of charges for individuals between 150 and 250 percent of the Federal poverty guidelines which is unpaid by other parties and billed to the patient exceeds 30 percent of the person's, or family's if applicable, annual income as calculated by reference to (b)2 above, this excess will be eligible for treatment as charity care. This 30 percent threshold must be met once per family in a 12 month period.

4. Family income that must be considered for an eligibility determination includes the income of all legally responsible individuals including, but not limited to, a spouse and any minor children for an adult and a parent and any minor siblings for a minor child. Only unearned income shall be considered for minor children and siblings. A patient may document that a parent or spouse's income is not available and that parent or spouses' income will not be considered.

(c) Assets eligibility criteria for identifying charity care and reduced charge charity care patients are as follows:

1. An individual is eligible for charity care or reduced charge charity care if:

i. His or her individual liquid assets do not exceed \$1,000; and

ii. His or her family's liquid assets, if applicable, do not exceed \$2,000.

2. Liquid assets are assets which consist of, or which can be readily converted into, cash. This includes, but is not limited to, cash, savings and checking accounts, certificates of deposit, treasury bills, negotiable paper, corporate stocks and bonds, and equity in real estate, other than the patient's or family's, if applicable, primary residence.

3. Family assets that shall be considered for eligibility determination include the assets of all legally responsible individuals including, but not limited to, a spouse and any minor children for an adult and a parent and any minor siblings for a minor child.

4. The assets of an applicant for charity care shall be counted only after the applicant has had an opportunity to apply any assets to the hospital charges for which the applicant seeks charity care.

(d) Eligibility determination for charity care and reduced charge charity care shall be as follows:

1. Based on the criteria in (b) and (c) above, hospitals shall determine the eligibility for charity care or reduced charge charity care for all New Jersey residents who present characteristics indicating an inability to pay for services including, but not limited to: absence of third party insurance coverage; receipt of unemployment or welfare benefits; limited income; and expressions of difficulty with paying for care. A patient with third party insurance coverage may still be eligible for charity care and reduced charge charity care and shall be screened for eligibility if he or she presents other characteristics indicating an inability to pay for services. A patient who is eligible for, but not enrolled in, Medicaid (Title XIX), for the services in question may not be determined to be eligible for charity care.

i. Hospitals shall make arrangements for reimbursement for services from private and Federal, state and local governmental third party payers when a person is found to be eligible for such payment. Hospitals shall collect from any party liable to pay all or part of a person's bill, prior to attributing it to charity care. The Hospital shall, as part of this obligation, pursue reimbursement for the uncollectible copayments and deductibles of indigent participants in Title XVIII of the Social Security Act (Medicare).

ii. A patient who is categorically and income eligible for Medicaid but who is determined to be ineligible for failure to provide information or documentation or for other administrative reasons may not be determined to be eligible for charity care.

2. A patient or responsible party may request a facility to make a determination for charity care or reduced charge charity care at any time up to one year from the date of service. A hospital may, at its discretion, accept applications after one year from the date of service. Such a determination shall be made as soon as possible, but no later than five working days from the day of the request. If the request does not include sufficient documentation to make such a determination, the request shall be denied. The hospital shall promptly provide the applicant with a written copy of the determination. If a denial of eligibility has been made because of inadequate documentation, the patient or responsible party shall be permitted to provide additional documentation.

3. A determination that an applicant is eligible shall indicate:

- i. That the facility will provide charity care services at no charge or at a specified charge which is less than the allowable charge for the services;
- ii. The date on which services were requested;
- iii. The date on which the determination was made;
- iv. The applicant's family size, income and eligibility computation;
- v. The date on which the services were or will be provided to the applicant; and
- vi. The length of time that the hospital will provide charity care based on this determination. A hospital shall not provide charity care on the basis of a determination of eligibility that is more than one year old.

4. The facility shall provide each applicant who requests charity care and is denied it, in whole or in part, with a written and dated statement of the reasons for the denial when the denial is made, including the information required in (d)3 above. In addition, this notice shall state that the applicant may reapply if the applicant believes his or her financial circumstances have changed so as to make him or her eligible for charity care for future services. The notice must also inform the applicant about the availability of an appeals process pursuant to (f) below. Where a denial is based on a presumption that the patient is eligible for, but not enrolled in Medicaid, the information upon which the denial is based must be documented.

5. A facility shall, as a condition of finding any applicant eligible for charity care or reduced charge charity care, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income and is within the applicant's ability to supply. Such proofs may include proof of receipt of welfare benefits, unemployment compensation, or proof of wage level as well as bank statements and other proofs of assets. The hospital shall retain proof that this documentation was provided.

6. Whenever the medical condition of the prospective patient so dictates, all necessary hospital services shall be provided prior to the financial screening or verification required by these rules.

7. Persons who are not New Jersey residents may not be screened for charity care pursuant to (d)1 above. Hospitals shall not report care delivered to non-New Jersey residents as charity care unless the care is related to an emergency situation resulting in an inpatient admission. Necessary and appropriate care may not be denied to non-New Jersey residents for failure to meet financial requirements pursuant to N.J.A.C. 8:31B-4.40(a). Hospitals may not report as either bad debt or charity care the costs of services delivered to persons who are brought to New Jersey by the hospital or other organization for the purpose of receiving medical care. With that exception, hospitals may report costs associated with care delivered to non-New Jersey residents as bad debt provided appropriate collection procedures are followed pursuant to N.J.A.C. 8:31B-4.40.

(e) Collection procedures and prohibited action requirements are as follows:

1. Persons determined to be eligible for charity care or reduced charge charity care pursuant to this section shall not be subject to the collection procedures set forth in N.J.A.C. 8:31B-4.40. Persons determined to be eligible for reduced charge charity care pursuant to these rules shall not be subject to the collection procedures set forth in N.J.A.C. 8:31B-4.40 for the portion of the bill that is reduced charge charity care. If the portion of the bill that will be reduced charge charity care cannot be determined prior to billing because third party payments have not been made, any statements shall indicate that part of the bill will be reduced charge charity care.

2. No demand for payment or collection action, including rendering a bill for services, shall be instituted against persons found eligible for charity care. No demand for payment, including the rendering of a bill for services, shall be instituted for the portion of the cost of services determined to be reduced charge charity care. A statement of charges may be sent as long as the statement clearly indicates that it is not a bill or demand for payment.

3. No demand for payment or collection action shall be instituted before a hospital screens a patient pursuant to N.J.A.C. 8:31B-4.37(d) and renders an eligibility determination.

4. Hospitals are prohibited from denying persons medically necessary treatment if the hospital has the medical capacity to provide such care.

(f) Appeals of denials of eligibility shall be conducted as follows:

1. Applicants who wish to appeal a decision regarding eligibility for charity care or reduced charge charity care must notify the Department in writing of their intention to appeal within 30 days of the applicant's receipt of the notice described in N.J.A.C. 8:31B-4.37(d)4.

2. The Department shall attempt to facilitate a mutually acceptable resolution of the dispute between the applicant and the hospital. The Department shall notify the applicant and the hospital of the results of such efforts within 60 days of its receipt of the applicant's notice of intent to appeal.

3. If no resolution of the dispute is obtained within this 60 day period, the Department shall transmit the matter to the Office of Administrative Law for resolution as a contested case pursuant to N.J.A.C. 1:1. In proceedings before the Office of Administrative Law, the Department shall be a non-adversarial party.

4. The hospital shall not pursue collection of payment from an applicant for charity care or reduced charge charity care until the completion of the administrative review process described in this section.

(g) Special eligibility for charity care under the Department's Reinsurance Program shall be as follows:

1. Patients who are insured under the Department's Reinsurance Program, which has negotiated terms of reinsurance with one or more insurance company or health maintenance organization in the State, are eligible for 100 percent charity care for that portion of their hospital bill which exceeds the predetermined amount as specified by the Commissioner. Deductibles and copayments are not affected by this provision.

2. Hospitals shall bill insurance companies and health maintenance organizations as usual. When an insurance company or health maintenance organization receives a hospital bill for one of its clients who is covered under the Department's Reinsurance Program for an amount which exceeds the predetermined amount, it shall transmit payment to the hospital for the portion for which it is responsible, along with an explanatory letter. The insurance company or health maintenance organization shall then forward a copy of the bill to the Department or its agent for continued processing.

3. The Department or its agent will verify that the client/patient is covered through the Reinsurance Program and send written authorization to the hospital to write off the balance of the bill as 100 percent charity care. The hospital shall keep this authorization in the patient's file for review by auditors.

4. The hospital shall not pursue payment for the amount of the bill which exceeds the predetermined reinsurance figure from the patient. However, the hospital shall pursue payment for any deductibles or copayments as is standard practice.

5. The Department or its agent shall keep a record of all patient bills which are insured under the Department's Reinsurance Program and will monitor the Program's impact on uncompensated care in the State.

New rule, R.1988 d.420, effective September 6, 1988.

See: 20 N.J.R. 595(a), 20 N.J.R. 2276(a).

Amended by R.1989 d.25, effective January 3, 1989.

See: 20 N.J.R. 2219(a), 21 N.J.R. 58(a).

Added new (b)3; added text to (c)2 "and equity in ..."; and added new (c)4 and (d)7.

Amended by R.1989 d.619, effective December 18, 1989 (operative January 1, 1990).

See: 21 N.J.R. 2448(a), 21 N.J.R. 3951(b).

Added new subsection (g) regarding Department's Reinsurance Program.

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Application of Poverty Income Guidelines clarified; all legally responsible family members' income and children's unearned income included.

Case Notes

County corrections officials could not enter into implied contract for hospital services for indigent inmate; hospital could recover in quasi-contract for expenses incurred during period of incarceration; cost of inmate's health care subsequent to expiration of his sentence to be borne by hospital, subject to its right to spread loss through statutory and regulatory mechanisms. *Saint Barnabas Medical Center v. Essex Cty.*, 111 N.J. 67, 543 A.2d 34 (1988).

8:31B-4.38 Charity care and reduced charge charity care

(a) Charity care includes only the reasonable cost of the following:

1. Charity care for services, provided the patient is qualified as eligible pursuant to N.J.A.C. 8:31B-4.37;

2. Advanced life support (ALS) services provided pursuant to P.L. 1984, c.146 (N.J.S.A. 26:2K-7 et seq.) provided the patient is qualified as eligible for charity care pursuant to N.J.A.C. 8:31B-4.37.

3. Charity care as defined by following N.J.A.C. 8:31B-4.37 for outpatient dialysis services provided after September 1, 1987 to patients ineligible for Medicare coverage. Reasonable costs shall be limited to the lower of the established Medicaid rate or the prospectively determined composite rate as established by Medicare. The amount reported by the hospital as charity care shall not include Medicare co-insurance amounts, since Medicare will reimburse providers for the amount, provided the patient is eligible for charity care pursuant to N.J.A.C. 8:31B-4.37.

(b) Charity care excludes the cost of the following:

1. Medical denials, which are services that are denied for lack of medical necessity by a utilization review organization (URO) or peer review organization, unless the denial is for days within the trim points;

2. Courtesy adjustments as defined in N.J.A.C. 8:31B-4.15(a)4;

3. Discounts provided to health maintenance organizations or other payers;
4. Patient Convenience Items as defined in N.J.A.C. 8:31B-4.65;
5. Excluded Health Services as defined in N.J.A.C. 8:31B-4.62;
6. Cosmetic surgery except where medically necessary;
7. Cost associated with procuring organs sent to foreign countries; and
8. Non-health services provided by a hospital.

Amended by R.1985 d.550, effective November 4, 1985.
See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

(a)1 substantially amended.

Amended by R.1988 d.276, effective June 20, 1988.
See: 19 N.J.R. 2092(c), 20 N.J.R. 1430(a).

Added (a)4.

Amended by R.1989 d.620, effective December 18, 1989.
See: 21 N.J.R. 2449(a), 21 N.J.R. 3953(a).

Provisions for advanced life support, exclusions from uncompensated care and specification regarding Chapter 83 service eligibility added.

Amended by R.1993 d.668, effective December 20, 1993.
See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

8:31B-4.39 (Reserved)

Amended by R. 1985 d.550, effective November 4, 1985.
See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Substantially amended.

Amended by R.1988 d.420, effective September 1, 1988.
See: 20 N.J.R. 595(a), 20 N.J.R. 2276(a).

Substantially amended (a)7 and 8; added (a)9 and 10.

Amended by R.1989 d.620, effective December 18, 1989.
See: 21 N.J.R. 2449(a), 21 N.J.R. 3953(a).

Uncompensated care amounts shall be specified, not estimated.

Repealed by R.1993 d.668, effective December 20, 1993.
See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

Section was "Determination of uncompensated care payments".

8:31B-4.40 Demographic Information

(a) Hospitals which are licensed to provide acute care services shall submit information about all inpatients and all outpatients to the Department of Health.

1. These hospitals shall submit quarterly information to the Department of Health for all patients who have balances which were written off to bad debt (in that quarter) and for all patients who were screened for charity care (in that quarter). This information shall be provided on media specified by the Department.

- i. Quarterly periods shall be: January 1 through March 31; April 1 through June 30; July 1 through September 30; and October 1 through December 31. The first quarter will be from January 1, 1993 through March 31, 1993.

ii. Information will be reported about each patient described in (a)1 above. This information will include: age; sex; marital status; health insurance coverage; health insurance coverage of the parent, spouse or responsible party (when the patient does not have insurance); hospital code number; county in which the hospital is located; employment status code; total charges; amount written off; reason for patient's failure to pay; DRG code (for inpatients); CPT-4 code (for outpatients); family income amount; family size; family assets amount; patient account number; Zip Code; financial screening status; subsidy approval percent; medical record number; treatment date; and treatment location.

Amended by R. 1985 d.550, effective November 4, 1985.
See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Substantially amended.

Amended by R.1989 d.620, effective December 18, 1989.
See: 21 N.J.R. 2449(a), 21 N.J.R. 3953(a).

Collection process specified in detail, including denial of service to non-emergency patients for failing or refusing to provide information.
Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Collection procedure clarified in (d)5.

Repeal and New Rule, R.1993 d.668, effective December 20, 1993.
See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

Section was "Appropriate collection procedures".

8:31B-4.41 Charity care audit functions

The Department of Health will conduct an audit of acute care hospitals' charity care in calendar year 1993 in accordance with N.J.A.C. 8:31B-4.41A through 4.41N.

New Rule, R.1989 d.152, effective March 20, 1989.

See: 20 N.J.R. 595(a), 21 N.J.R. 754(a).

Repeal and New Rule, R.1993 d.592, effective November 15, 1993.
See: 25 N.J.R. 3707(a), 25 N.J.R. 5154(a).

Section was "Uncompensated care audit functions".

EDITOR'S NOTE: Sections 8:31B-4.41A through 8:31B-4.41N, following, were adopted as New Rules, R.1993 d.592, effective November 15, 1993. See: 25 N.J.R. 3707(a), 25 N.J.R. 5154(a).

8:31B-4.41A Sampling methodology

(a) The Department of Health will audit charity care claims based on a sample which will be developed in the following way:

1. Hospitals shall maintain their charity care list in a way that will allow the Department of Health to select accounts for unit dollar sampling. The list should include patient name, account number, write-off date, and write-off amount. Hospitals shall rank order all charity care accounts from the smallest to the largest, based on the rate that Medicaid would have paid for each account, and run a cumulative dollar balance on the list. Once the selection of sample dollars has been completed and the associated patient accounts have been identified, hospitals will be required to retrieve the patient account files according to the following schedule:

Number of files to be retrieved	Time to retrieve
300-500 files	One week
501-1100 files	Two weeks
1101-1800 files	Three weeks
1801 files and above	Four weeks

(b) The Department of Health will require hospitals to make a small number of additional charity care accounts available upon audit.

8:31B-4.41B Charity care write off amount

(a) Hospitals shall record inpatient and outpatient charity care write-off amounts at the rate paid by the Medicaid program on the date that the service was provided as described in (a)1 below. Inpatient Medicaid rates are determined by grouper assignment applied to the rate per case amounts established by the Medicaid Program. Outpatient Medicaid rates are determined using Medicaid principles for a given outpatient service. In the event that a hospital did not record all charity care write-offs at the Medicaid rate, the hospital must convert such accounts to the Medicaid rate in preparing the charity care list for audit.

1. Charity Care Write Off Amount = (Charity Care Eligibility Percentage, as determined by N.J.A.C. 8:31B-4.41H) × (Medicaid Payment Rate)

2. In the event that there is a partial payment from a third party, the charity care write-off amount is determined as follows:

$$\text{Charity Care Write Off Amount} = (\text{Medicaid Payment Rate} - \text{Third Party Payment}) \times (\text{Charity Care Eligibility Percentage})$$

3. If the third party payment is greater than the Medicaid payment rate, then the charity care write-off amount shall be listed as 0.

(b) Patients eligible for charity care at 100 percent shall not be billed. Any difference between hospital charges and the Medicaid rate shall be recorded as a contractual allowance.

(c) Patients eligible for charity care at less than 100 percent shall be billed as follows:

$$\text{Patient Responsibility} = (100\% - \text{Charity Care Eligibility Percentage}) \times (\text{Hospital Charges} - \text{any third party payment})$$

$$\text{Contractual allowance} + (\text{Hospital Charges} - \text{any third party payment}) - (\text{Charity Care Write Off} + \text{Patient Responsibility})$$

8:31B-4.41C Posting of notice of availability of charity care

(a) Hospitals shall post notification of the availability of charity care as follows:

1. The Department shall provide to acute-care hospitals notices in English and Spanish about the availability of charity care and reduced charge charity care. Hospitals shall post such notices, provided by the Department, of the availability of charity care in areas of the facility readily accessible and visible to incoming patients, including but not limited to, the admissions area, the business office, outpatient clinic areas, and the emergency room.

2. If the usual language of the households of 10 percent or more of the population in the service area of the facility, according to the most recent figures published by the Bureau of Census, is other than English or Spanish, the facility shall notify the Department, who shall translate the notice into that language and supply the posted notice to the facility. The facility shall then also post the translated notice.

3. The Department shall request the auditors to complete a list of all hospitals which failed to post the charity care notification signs described in (a)1 and 2 above.

(b) Hospitals which failed to post the notification signs will be required to place an advertisement in their local newspaper notifying the public that the hospital will accept applications for patients who received services prior to the date when the signs were placed.

8:31B-4.41D Charity care screening and documentation requirements

(a) The hospital shall correctly assess and document the patient's eligibility for charity care, based upon the criteria set forth in N.J.A.C. 8:31B-4.41A through N. The patient's financial file for audit shall contain the completed charity care application, as well as the supporting documentation which led to the determination of eligibility. The hospital may, for purposes of the audit, construct a file containing the information required for the audit to present to the auditors.

(b) The hospital shall ask the patient if he or she has any third party health insurance. If the patient claims to have insurance, the hospital shall document the name of the insurer and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified; or the reason why the coverage could not be verified. Verification of insurance may be accomplished by a phone call by hospital staff to the third party insurer.

(c) If the patient is uninsured, or the patient's health insurance is unlikely to pay the bill in full (based on hospital staff's previous experience with the insurer), and the patient has not paid, at the time of service, any amounts likely to be remaining, the hospital shall make an initial determination for eligibility for any medical assistance programs available. The hospital shall refer the patient to the appropriate medical assistance program and shall advise the medical assistance office of the patient's possible eligibility. The patient's financial file for audit shall indicate either that the patient declined to be screened for medical assistance; that the patient was screened but was determined ineligible; or that the patient was screened and referred to the New Jersey Medicaid medical assistance program for possible eligibility. If the hospital does not screen the patient for medical assistance, the record shall indicate the reason(s) why the patient was not screened and the efforts the hospital made to obtain the screening. A patient shall not be screened for charity care if the patient declines to be screened for medical assistance or if the patient does not receive a denial from the medical assistance agency.

(d) Hospitals shall make arrangements for reimbursement for services from private, and Federal, state and local government third party payers when a person is found to be eligible for such payment. Hospitals shall collect from any party liable to pay all or part of a person's bill, prior to attributing the services to charity care except in the situation described in (h) and (i) below. The hospital shall, as part of this obligation, pursue reimbursement for the uncollected copayments and deductibles of indigent participants in Title XVIII of the Social Security Act (Medicare).

(e) A patient who is categorically and income-eligible for Medicaid but who is determined to be ineligible for failure to provide information or documentation or for other administrative reasons shall not be determined to be eligible for charity care.

(f) A patient who is responsible for complying with his or her insurer's pre-certification requirements (the specific steps with which the insured must comply in order to have the services reimbursed) shall not be determined to be eligible for charity care, if the bill was unpaid because he or she failed to comply with these requirements.

(g) A patient who is determined to be eligible for and accepted into the HealthStart or HealthStart Plus Programs shall not be deemed eligible for charity care for services which are covered under those programs.

(h) Applicants who are eligible for reimbursement under the Violent Crimes Compensation Program shall be screened for eligibility for the charity care program before referral to the Violent Crimes Compensation Program. If the applicant is not eligible for 100 percent coverage under the charity care program, then the charges which are not eligible for coverage under charity care shall be referred to the Violent Crime Compensation Program. The hospital

shall request the patient to submit a copy of his or her charity care determination form to the Violent Crimes Compensation Board.

(i) Applicants who are eligible for reimbursement under the Catastrophic Illness in Children Relief Fund shall be screened for eligibility for the charity care program in accordance with N.J.A.C. 8:18 before referral to this Program. If the applicant is not eligible for 100 percent coverage under the charity care program, then the patient shall be referred to the Catastrophic Illness in Children Relief Fund.

8:31B-4.41E Identification

(a) Applicants for charity care shall provide the hospital with proper identification:

1. Documentation of identification may include, but is not limited to, a driver's license, a voter registration card, an alien registry card, a birth certificate, an employee identification card, a union membership card, an insurance or welfare plan identification card or a Social Security Card. Identification may also be documented by personal recognition by a person not related to the patient.

(b) Hospitals shall obtain a copy of the applicant's identification and produce the copy on audit. The copy of identification may be made in one of two ways: a photocopy of the identification may be made; or hospital staff may copy all pertinent information from the identification source, such as, driver's license number, passport/visa number, and put this information in the patient file for audit. If documentation of identification is provided by personal recognition by a person not related to the patient, the record must include the name, address and phone number of the person who provided the recognition.

(c) Hospitals shall attempt to collect the following information regarding the patient and responsible party (if applicable): name, mailing address, residence telephone number, date of birth, Social Security number, place and type of employment, employment address and telephone number, as applicable.

8:31B-4.41F New Jersey residency

(a) Applicants shall provide the facility with proof of New Jersey residency. Proper proof of New Jersey residency includes the following items: any of the identification listed in N.J.A.C. 8:31B-4.41E which contains the applicant's mailing address, a copy of a deed or lease to a property in New Jersey, an article of mail sent to the patient at a New Jersey address, or a letter from a New Jersey resident with whom the applicant is living stating that the applicant resides with him or her.

(b) An applicant shall provide proof that he or she has been residing in New Jersey for at least three months prior

to the date of service, and that he or she has the intent to remain in the State.

(c) Persons who are not New Jersey residents shall not be screened for charity care, unless the care results from an emergency situation requiring immediate medical care. Hospitals shall not report care delivered to non-New Jersey residents as charity care, unless the care is related to an emergency situation requiring immediate medical care. Hospitals shall not report the costs of services delivered to persons who come to New Jersey for the purpose of receiving medical care as charity care.

8:31B-4.41G Documentation of family size

The hospital shall properly determine the applicant's family size in accordance with this section. Family size for an adult applicant includes the applicant, spouse, any minor children whom he or she supports, and adults for whom the applicant is legally responsible. The family size for a minor applicant includes both parents, or a spouse of a parent, minor siblings and any adults in the family for whom the applicant's parent(s) are legally responsible. If an applicant documents that he or she has been abandoned by a spouse or parent, then that spouse or parent is not included as a family member. A pregnant female counts as two family members.

8:31B-4.41H Income eligibility criteria and documentation

(a) The provisions of 42 U.S.C. 990c(2), the poverty income guidelines revised annually by the United States Department of Health and Human Services, are hereby incorporated by reference. (For further information on the poverty income guidelines, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C. 20201, telephone 202-245-6141). A person is eligible for charity care or reduced charge charity care if he or she falls into one of the following categories:

1. A person whose individual or, if applicable, family income, as determined by reference to (b) below, is less than or equal to 200 percent of the HHS Income Poverty Guidelines shall be eligible for charity care for necessary health services without cost.

2. A person whose individual or, if applicable, family income as determined by reference to (b) below, is greater than 200 percent of the HHS Income Poverty Guidelines but not more than 300 percent of these guidelines is eligible at a reduced rate as described in subsection (b) below.

(b) A person who is eligible for reduced charge health services shall be charged a percentage of the normal charge for health services as follows: the reduced percentage can be applied to the total bill or to any remainder after third party payment.

Income as a Percentage of HHS Income Poverty Guideline	Percentage of Charges Paid by Patient
>200 to 225	20
>225 to 250	40
>250 to 275	60
>275 to 300	80

(c) If the liability (which is unpaid by other parties and billed to the patient) for individuals with incomes between 200 and 300 percent of the Federal poverty guidelines to the patient exceeds 30 percent of the person's, or family's if applicable, annual gross income as calculated by reference to (b) above, this excess will be eligible for 100 percent coverage under the charity care. This 30 percent threshold must be met once per family in a 12 month period.

(d) A person's income, for purposes of determining eligibility for charity care or reduced charge charity care, shall be determined as follows:

1. The applicant may provide proof of the actual gross income for the 12 months immediately preceding the services;

2. The applicant may provide proof of actual gross income for the three months immediately preceding services. The facility will multiply this amount by four to determine the gross annual income; or

3. The applicant may provide proof of actual gross income for the prior month immediately preceding service. The facility will multiply this amount by 12 to determine the gross annual income.

4. If the applicant provides documentation for more than one salary period, the facility shall use the period of time during which the salary was the lowest.

5. If the applicant is a welfare recipient, the facility may document income status by obtaining a photocopy of the applicant's welfare identification, and documenting that the staff of the facility communicated with the local welfare office, either by telephone or in writing, to verify the applicant's current benefit amount.

6. An applicant may request that unreported income be considered in the eligibility determination, as described in N.J.A.C. 8:31B-4.41I(b).

8:31B-4.41I Proof of income

(a) Proof of income shall include Federal or state income tax return, pay check stubs, W-2 forms, a letter from an employer on company letterhead stating the applicant's income, or a statement of the gross benefit amount from any governmental agency providing benefit to the applicant. An applicant may document his or her income by providing one paycheck stub immediately prior to the date of service if the paycheck stub indicates a year to date income, and if the applicant documents the length of time he or she has been employed by the employer.

1. An applicant may document unreported income, by signing an attestation which states the income obtained in one of the time periods described in N.J.A.C. 8:31B-4.41H(d)1, 2 or 3. The facility may request that the applicant document his or her living expenses for the same time period.

2. An applicant who receives no income or benefits may provide the hospital with an attestation(s) from organizations, or people providing the applicant with support. If the applicant has not received cash assistance, the applicant will be evaluated at \$0 gross income.

3. If the applicant is homeless, the facility may accept a signed attestation from the applicant which states that he or she is homeless and receives no support, income or benefits.

(b) Family income that must be considered for the eligibility determination includes the income of all members for whom the applicant is legally responsible including, but not limited to, a spouse and any minor children for an adult. For a minor applicant, the income of the family, as determined by N.J.A.C. 8:31B-4.41H, will be considered. In situations where a minor applicant's parents are divorced, and the custodial parent(s) are remarried, the nonparental spouse's income shall be considered. In situations where both divorced parents have responsibility for the minor applicant's medical care each parent shall complete a charity care application. For a minor applicant the income of the family shall be considered. Only unearned income shall be considered for minor children and siblings. In cases where an adult applicant has been abandoned by a spouse, or a minor applicant has been abandoned by a parent, the applicant may document that a spouse's or parent's income is not available.

(c) If a minor applicant's parents are divorced, and one of the parents is uncooperative, as explained in (c)1 through 3 below, with the application process, then the requirement for that parent's income may be waived after the case is reviewed by the Department of Health.

1. A parent or spouse may be deemed uncooperative if the applicant documents the unsuccessful attempts to obtain the necessary information from the parent or spouse; and

2. The parent or spouse does not respond to a letter from the hospital threatening collection or legal action if he or she does not provide the necessary information for the application; and

3. The parent or spouse does not respond to the hospital's inhouse collection process.

(d) The hospital may request that the applicant document his or her living expenses.

8:31B-4.41J Assets eligibility criteria

(a) An individual is eligible for charity care or reduced charge charity care if:

1. His or her individual assets as of the date of service do not exceed \$3,000; and

2. His or her family's assets, if applicable, do not exceed \$6,000 as of the date of service.

(b) Family members whose assets must be considered are all legally responsible individuals as defined in N.J.A.C. 8:31B-4.41I(b).

(c) Assets, as used in this section, are assets which consist of, or which can be readily converted into, cash. This includes, but is not limited to, cash, savings and checking accounts, certificates of deposit, treasury bills, negotiable paper, corporate stocks and bonds, IRAs (Individual Retirement Accounts), trust funds, and equity in real estate other than the patient's or family's, if applicable, primary residence. A primary residence, for purposes of charity care, is defined as a residence zoned for a single family in which the applicant currently lives.

(d) Where applicable, the applicant may document his or her or family assets by presenting the hospital with documentation of the value of any of the assets as of the date of service, or, in the case of a checking or savings account, provide a statement of the average daily balance of the accounts for the month in which he or she received services.

(e) The assets of an applicant for charity care shall be counted only after the applicant has had an opportunity to apply any amount of assets in excess of the limits in (a) above to the hospital charges for which the applicant seeks charity care.

8:31B-4.41K Additional information to be supplied to facility by applicant

A facility shall, as a condition of finding any applicant eligible for charity care or reduced charge charity care, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income and assets and that is within the applicant's ability to supply.

8:31B-4.41L Application and determination

(a) The Department of Health shall provide acute care hospitals with a standardized application and determination form. This application and determination form shall be used by all acute care hospitals for the charity care program.

(b) A patient or responsible party may request a facility to make a determination for charity care or reduced charge charity care at any time up to one year from the date of service. A hospital may, at its discretion, accept applications after one year from the date of service. Such a determination shall be made as soon as possible, but no later than 10 working days from the day an applicant

submits a completed application to the hospital. If the request does not include sufficient documentation to make such a determination, then the applicant shall be permitted to supply additional documentation. The hospital shall promptly provide the applicant with a written copy of its final determination.

(c) A determination that an applicant is eligible shall indicate:

1. The date on which the eligibility determination was made;
2. The date on which hospital services were requested;
3. The date on which the services were or will be provided to the applicant;
4. That the facility will provide charity care services at no charge or at a specified charge which is less than the allowable charge for the services;
5. The applicant's family size, income and eligibility computation; and
6. The length of time that the hospital will provide charity care based on this determination. A hospital shall not provide charity care on the basis of a determination of eligibility that is more than one year old.

(d) The facility shall provide each applicant who requests charity care and is denied it, in whole or part, with a written and dated statement of the reasons for the denial, including information required in (c) above. In addition, this notice shall state that the applicant may reapply if the applicant believes his or her financial circumstances have changed so as to make him or her eligible for charity care for future services. Where a denial is based on a presumption that the patient is eligible for, but not enrolled in, Medicaid, the information upon which the denial is based must be documented.

8:31B-4.41M Collection procedures and prohibited action

Persons determined to be eligible for charity care shall not receive a bill for services or be subject to collection procedures. Persons determined to be eligible for reduced charge charity care shall not be billed or subject to collection procedures for the portion of the bill that is reduced charge charity care. If the portion of the bill that will be charity care cannot be determined prior to billing because third party payments have not been made, any statements shall indicate that the portion of the bill eligible for reduced charge charity care will be identified at a future date.

8:31B-4.41N Adjustment methodology

(a) For listing adjustment, the charity care write off amount for each account should agree with the reimbursement rate that would have been paid to the hospital by the Medicaid program. To the extent that charity care write off amounts are overstated, the hospital's listing total will be reduced by the percentage of overstatement found in the sample accounts.

(b) For compliance adjustment, each file reviewed must pass the eight compliance steps in N.J.A.C. 8:31B-4.41D through 4.41M. Failure in any one step would fail the file and associated sample dollars. A failure rate (failed dollars/total dollars sampled) that meets or exceeds 10 percent would require an adjustment to the hospital's charity care listing total based on unit dollar sampling.

(c) The hospital's adjusted charity care listing total will constitute the hospital's audited 1993 charity care amount.

(d) A hospital which disagrees with the Department's listing adjustment may request an administrative hearing, which shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

8:31B-4.42 Capital facilities¹

(a) Buildings and Fixed Equipment:

1. The costs of Capital Facilities used for Services Related to Patient Care as defined in N.J.A.C. 8:31B-4.21, except for Major Moveable Equipment as defined in 8:31B-4.21 and 4.44, are included as financial elements for all hospitals through a Capital Facilities Allowance calculated in accordance with N.J.A.C. 8:31B-3.27(a)1i through vii.

2. The amount of Revenue Related to Patient Care prospectively included for Capital Facilities in a hospital's Preliminary Cost Base and Schedule of Rates is to be funded, in the form of cash and/or investments, in the Internally Generated Plant Replacement and Renovation Fund (Plant Fund). Use of the Plant Fund, including any income (net of income taxes) generated by the fund, is restricted to the payment of Capital Cash Requirements and renovations and down payment on replacement of buildings, building components, and fixed equipment where Certificate of Need approval has been granted.¹ For those hospitals which, as part of a debt service agreement relating to Capital Facilities, are or will be required to establish and fund a Restricted Debt Service Reserve Fund, all the revenue included for Capital Facilities in those hospital's Schedule of Rates must be placed in the Reserve Fund as it is received. Once the Reserve Fund is fully funded, it must remain so for the period of time specified in the debt service agreement. Only after the Reserve Fund has been fully funded can the hospital utilize Capital Facilities revenue for other approved purposes.

3. The hospital's governing board, subject to the Certificate of Need process, may use the Plant Fund for appropriate needs of the hospital's service area including the development of multi-institutional programs, the merging of the hospital with other institutions, the provisions of service in alternate modes or settings, or the reduction or elimination of services in an orderly manner including employee relocation, provision for pension rights, and other costs associated with ceasing operation.

Amended by R.1988 d.24, effective January 4, 1988.
See: 19 N.J.R. 1145(a), 20 N.J.R. 77(b).
Deleted old (a)1 and substituted new.

¹ For Profit Hospitals who may be subject to taxes on interest income generated on the Plant Fund or any portion of the Plant Fund tax officials deem to be taxable income, may properly pay such taxes from the Plant Fund. After completion of final reconciliation (see N.J.A.C. 8:31B-3.71-3.87) and upon receipt by the Department of adequate documentation that such payments have been made, they shall be added to the Capital Facilities Formula Allowance indirect portion of the next year's Schedule of Rates. For Profit Hospitals shall not be required to fund depreciation payments for Capital Facilities.

8:31B-4.43 (Reserved)

8:31B-4.44 Major Moveable Equipment¹

Major Moveable Equipment, as defined in 8:31B-4.21 includes straightline depreciation costs on owned or capitalized leased Major Moveable Equipment plus a Price Level Depreciation Allowance in excess of this historical depreciation (see 8:31B-3.27(a)2 for the explanation of how this allowance is calculated) and operating lease/rent payments relative to Major Moveable Equipment utilized for Services Related to Patient Care. Leased Major Moveable Equipment is to be capitalized or reported as operating lease costs in accordance with Generally Accepted Accounting Principles.² Major Moveable Equipment Costs so determined are reported as a Natural Classification of Expense (see 8:31B-4, Part III, below) of each cost center. Major Moveable Equipment utilized by more than one functional cost center must be assigned to the using cost centers based on an estimate of each center's utilization. Capitalized repair and installation costs should be included with the cost of the equipment. (See also 8:31B-4.32.) Interest associated with capitalized financing purchases or leases is to be excluded and reported as a reconciliation, per 8:31B-4.66(e), since the Internally Generated Major Moveable Equipment Replacement Fund is established to provide sufficient funds to replace purchased equipment or meet installment payments for financed equipment (both principal and interest).

Amended by R.1982 d.449, eff. December 20, 1982.
See: 14 N.J.R. 946(b), 1457(a).
Footnotes amended.

¹ For-Profit hospitals shall be reimbursed for major moveable equipment through straightline depreciation, and interest as reported in accordance with Section I.

² See Financial Accounting Standards Board Statement of Financial Accounting Standards Numbers 13, 17, and 23.

8:31B-4.45 (Reserved)

8:31B-4.46 Reasonable Working Capital

(a) Working Capital, the difference between current assets and current liabilities, is included as a financial element through:

1. Provision for an initial infusion of working capital for those hospitals lacking a reasonable working capital position as of the date of issuance of their initial Commission approval Schedule of Rates; and

2. An ongoing working capital provision for all hospitals, i.e., working cash increases. (For this purpose, the current portion of long term debt payments is not to be included in current liabilities because this financial element is treated separately.)

(b) In the absence of unusual circumstances, if all patients paid for service when rendered, there would be no net working capital requirements to be derived from Revenues Related to Patient Care. Therefore, Working Capital increases are tied to delays in payments after services are rendered.

(c) Accordingly, achieving equity among payors requires that this financial element be included in payments in relation to the duration of time between the rendering of services and the receipt of payment. The cost to the payor should also have a reasonable relationship to the cost of money, i.e., to interest rates that hospitals could reasonably be expected to pay for working capital loans, where the interest income is taxable to the lender.

(d) Subject to change with significant changes in interest rates (that is, so long as interest rates are between six percent and 20 percent per annum), the cost of working capital required is defined as one percentage of patient services billings per month for the approximate period of time between the final billing services and the payment therefore. To encourage prompt timely payments and to minimize potential late payment "penalties," Hospitals' Schedule of Rates shall include a provision for working capital requirements of five percent of Gross Revenue Related to Patient Care in addition to all other approved financial elements subject to the determination by the Commission of quantifiable economic benefits for prompt payment by payers.

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).
Stylistic changes.

Case Notes

Regulations contemplate participating hospitals would have or be provided with adequate initial working capital; two phases of working capital recognized. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

8:31B-4.47 Return on investment

(a) Because of all of the costs for which non-profit hospitals require a return on investment are provided elsewhere under allowable financial elements (e.g., working capital, replacement costs in excess of historical costs, i.e., Major Moveable Equipment Price Level Allowance and Capital Facilities Formula Allowance) it is not included as a distinct Financial Element.

(b) However, because the Major Moveable Equipment Price Level Allowance is not available to for-profit hospitals and because for-profit hospitals have obligations that non-

profit hospitals do not, e.g., income taxes and stockholder returns, for-profit hospitals shall receive, as a distinct Financial Element, a return on investment calculated in the manner described in N.J.A.C. 8:31B-3.29(b).

Amended by R.1985 d.550, effective November 4, 1985.
See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Case Notes

Hospitals lacking adequate initial working capital received one-time rate adjustment so operations could begin with reasonable working capital under regulation; reasonable working capital standard. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

Former regulation pertained to working capital increases, cost of working capital and relation of working capital to rate schedule. In re: Barnet Memorial Hospital Rates, 92 N.J. 31, 455 A.2d 469 (1983).

8:31B-4.48 through 8:31B-4.50 (Reserved)

PART III. NATURAL CLASSIFICATIONS OF EXPENSE

8:31B-4.51 Salaries and Wages

Salaries and Wages are remuneration, including stipends, payable in cash, for services performed by an employee for a hospital, except a physician, including compensation for time not worked such as on call, vacation, holiday and sickpay; or the monetary value assigned to direct services provided to the hospital by a person performing in an employee relationship. Salaries and wages are reported per N.J.A.C. 8:31B-4.131. Monetary value is not to be assigned to the services of students or other volunteer workers. All labor costs (including deferred income which qualifies as pension costs) shall be included in the accounting period during which the employee accrues the remuneration for their services.

8:31B-4.52 Physician Compensation—Hospital Component¹

That portion of compensation for a physician's (M.D., D.O., D.D.S./M.D.) activities, provided through agreement with a hospital, representing services which are not directly related to an identifiable part of the medical care of an individual patient is the hospital component of physician compensation, and must be split between salaries and fees per N.J.A.C. 8:31B-4.131. Hospital services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as a part of the physicians' hospital service activities. The allocation of physician compensation between hospital and professional components and documentation thereof is to be in accordance with Medicare HIM-15, Section 2108 for provider component.

¹ In an amendment to the Financial Elements and Reporting, entitled Uniform Cost Reporting Regulation, these categories were reagggregated into the SHARE grouping in order to simplify the reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format.

8:31B-4.53 Physician Compensation—Professional Component¹

That portion of compensation for a physician's services provided through agreement with a hospital pertaining to activities which are directly related to the medical care of an individual patient is the professional component of physician compensation, (i.e., remuneration for the identifiable medical services by the physician which contribute to the diagnosis of the patient's condition or to his treatment) and must be split between salaries and fees per N.J.A.C. 8:31B-4.131. The allocation of physician compensation between hospital and professional components and documentation thereof is to be in accordance with Medicare HIM-15, Section 2108.

¹ In an amendment to the Financial Elements and Reporting, entitled Uniform Cost Reporting Regulation, these categories were reagggregated into the SHARE grouping in order to simplify the reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format.

8:31B-4.54 Employee Fringe Benefits

Employee Fringe Benefits are amounts paid to or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death. Fringe Benefits associated with physicians are to be reported with physician's compensation. Pensions, annuities and deferred income arrangement costs for past and current services are to be accounted for and reported in accordance with Employee Retirement Insurance and Security Act (ERISA) and Internal Revenue Service (IRS) requirements. Employee Fringe Benefits include FICA, State and Federal unemployment insurance, disability insurance, life insurance, employee health insurance, retirement (net of actuarial and realized gains on the investment of related funds), worker's compensation insurance, other payroll related employee benefits, tuition reimbursement and other training, moving expenses of new employees of a non-recurring nature, the cost of providing free or subsidized meals or cost to the employee at less than charges to employees, employee parking lot costs net of any revenue received for operation of facility, and other non-payroll employee benefits. The cost of providing health care services to employees is included in classifications of expense in various cost centers providing the funds. Where a hospital elects to self-insure for worker's compensation or unemployment insurance, costs reported should be the amounts set aside for that accounting period plus associated administrative costs, where a separate fund has been established, to the actual amounts of claims paid during the accounting year if a fund is not established. (See N.J.A.C. 8:31B-4.24.) Where a hospital provides free or subsidized health care services to employees or physicians, the hospital's customary charges should be generated and accounted for separately as personnel health allowances. (See N.J.A.C. 8:31B-4.15.) In order to preserve comparability of hospital expenses for provision of direct patient care, purchased employee health insurance expenses are reported as a separate cost center and not distributed to the labor costs of each center. Employee Fringe Benefits are assigned to the cost center in which the employee's compensation is reported on the following bases per N.J.A.C. 8:31B-4.131.

Benefit	Basis of Assignment
FICA—non-physician physician	Direct Cost
All other Payroll Related Benefits including Unemployment Insurance, Disability Insurance, Worker's Compensation and Pension and Retirement	
Life Insurance	Salaries
Employee Education and Training	Salaries or FTEs
Room and Board	FTEs
Cafeteria	FTEs
Parking Lot	FTEs

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

Case Notes

Provision for allocation of employee fringe benefits, including pension and dental plans; remand to Commission for proper determination regarding inclusion of plans in care cost reimbursement. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

8:31B-4.55 Medical and Surgical Supplies

(a) Medical and Surgical Supplies are medically necessary supplies, appliances, and minor moveable equipment (as defined in N.J.A.C. 8:31B-4.20) furnished by and used at a hospital for the care and treatment of a patient during a patient's episode of hospital care, and reported per N.J.A.C. 8:31B-4.131. Medically necessary supplies exclude all supplies furnished by a hospital but used by a patient after his episode of care except those items where it would be medically unreasonable to limit the patient's use of the item to his episode of hospital care. (See N.J.A.C. 8:31B-4.20 for the reporting of minor moveable equipment.) Take home supplies for rental Dialysis and Home Health Care should be included to the extent set forth in Medicare HIM-29 and HIM-11 respectively. The fair market value of donated Medical and Surgical Supplies is assigned to this classification if the commodity would otherwise be purchased by the hospital.

(b) Medical and Surgical Supplies include prosthetic devices, surgical supplies, anesthetic materials, oxygen and other medical gases, intravenous solutions, drugs including medically prescribed food supplements, biologicals, admission kits furnished by the hospital to inpatients not possessing such materials, and other medical care materials. The purchase cost of blood and blood components is excluded.

(c) The invoice/inventory cost and related revenue of all Medical and Surgical Supplies for which a separate charge is made to a patient for the use or consumption of the supply must be reported in the Medical and Surgical Supplies or Drugs Sold to Patients cost and revenue centers.

(d) Medical and Surgical Supplies issued by Central Supply services or Pharmacy for which a separate charge is not made to a patient must be accounted for as an interdepartmental transfer at invoice/inventory cost to the cost center using the supplies and materials. The costs of reuseable patient non-charged items used by more than one functional center must remain in or be transferred to the Central Supply Services cost center. (See Part V.) The costs of reuseable patient non-charged items used by one functional center should be reported in that center. The cost of other Medical and Surgical Supplies not requisitioned from Central Supply Services and for which a separate charge is not made to a patient must be reported in the functional cost center in which the supplies and/or materials are consumed.

(e) The overhead associated with the issuing of Medical and Surgical Supplies are to be reported in the Central Supply Services or Pharmacy cost centers. Except for reus-

able supplies (in (d) above) and differences between beginning and end of year inventories, no Medical and Surgical Supplies are to be reported in the Central Supply Services or Pharmacy cost centers.

8:31B-4.56 Non-Medical and Non-Surgical Supplies¹

Non-Medical and Non-Surgical Supplies include the invoice/inventory cost of supplies, instruments, and minor equipment (other than Medical and Surgical Supplies) required for the operation of a hospital for purposes other than the direct provision of care to a patient and reported in the using cost and revenue center per N.J.A.C. 8:31B-4.131. All rebates and quantity purchase discounts are to be offset against these costs as a reconciliation per N.J.A.C. 8:31B-4.66(c) and 8:31B-4.131.

¹ In an amendment to the Financial Elements and Reporting, entitled Uniform Cost Reporting Regulation, these categories were reagggregated into the SHARE grouping in order to simplify the reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format.

8:31B-4.57 Purchased Services

Purchased Services include the cost of all services purchased that could be accomplished by a hospital's own employees but for which the hospital elects to contract (not necessarily with a formal contract) and reported per N.J.A.C. 8:31B-4.131. All physician services are classified as physician compensation.

8:31B-4.58 Other Direct Expenses

Other Direct Expenses include all other direct non-capital operating expenses not classified elsewhere and reported per N.J.A.C. 8:31B-4.131 for Costs Related to Patient Care. Other Direct Expenses include utilities, non-physician professional fees, licensing fees, dues assessments, travel, postage, printing and duplicating costs, outside training sessions, subscriptions, paid taxes as defined in N.J.A.C. 8:31B-4.34 and insurance other than employee fringe benefit insurance programs.

8:31B-4.59 Major Moveable Equipment

Major Moveable Equipment, as defined in N.J.A.C. 8:31B-4.21 are expenses to be included in the costs of each center at historical depreciation costs (or both owned and capitalized leased equipment) and operating lease expenses. Interest expense incurred through purchase or capitalized leases of Major Moveable Equipment is not included with Major Moveable Equipment costs and is reported per N.J.A.C. 8:31B-4.66(e).

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.60 (Reserved)

PART IV. RECONCILIATION OF COSTS AND REVENUES RELATED TO PATIENT CARE WITH HOSPITAL UNRESTRICTED FUND EXPENSES AND REVENUES

8:31B-4.61 Reports of costs and revenues

(a) Expenses incurred and revenues generated by a hospital for items not included in the definitions of Services Related to Patient Care (i.e., Routine Services, Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services) are classified as either other operating expenses and revenues (determined per N.J.A.C. 8:31B-4.131) or non-operating revenue and are to be accounted for separately to determine if and how they will be applied to Costs Related to Patient Care and the Capital Facilities Allowance to determine the hospital total financial elements or the Current Cost Base. There are three cases into which income is classified:

1. Case A—Expenses and revenues related to activities which the hospital has selected to engage in but which are not an integral part of, or necessary for, the provision of patient care. Such expenses and revenues are netted against each other.
2. Case B—Expenses and revenues related to activities which the hospital has elected to engage in and which are an integral part of, or necessary for, the provision of patient care. Such expenses and revenues are netted against each other.
3. Case C—Expenses and revenues related to activities which are specifically included under N.J.A.C. 8:31B-4.62 through 4.66. Expenses and revenues are not netted against each other.

(b) Items of other operating expense and revenue are excluded from Services Related to Patient Care reporting centers through reporting in N.J.A.C. 8:31B-4.131. Other operating expenses and revenues so determined, in addition to non-operating revenues, are to be classified in N.J.S.A. 8:31B-4.131, to account for all revenue and expense transactions of the hospital's Unrestricted Fund per the hospital's financial statements. Accounting differences between the hospital's financial statements and the Financial Elements Report are to be reconciled per N.J.A.C. 8:31B-4.131.

(c) Other operating expenses and revenues and non-operating revenues are to be categorized below as:

1. Excluded health care services;
2. Education and research;
3. Sales and services not related to patient care;
4. Patient convenience items;
5. Administrative items; and
6. Other income.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.62 Excluded Health Care Services

(a) Non-Acute Care Services provided by a hospital such as skilled nursing facilities (approved or unapproved); intermediate care facilities, residential care, long term psychiatric care, long term rehabilitation and intermediate care services are not properly acute hospital functions, and hence are excluded and treated as Case C. Sufficient accounting records should be maintained to account for the costs of such operations (i.e., Medicare cost funding SSA-2552 or SSA-2551) and such costs should be excluded from Costs Related to Patient Care by cost center per N.J.A.C. 8:31B-3.19(c) and 3.24.

(b) Organ Donations: Organs acquired by a hospital and donated to a pool or patient at another hospital are not properly service related to care of patients at the donating hospital, and hence costs and revenues are not included in the service definitions. The acquisition costs incurred should be accounted for in accordance with the definition of the Organ Acquisition cost center (see N.J.A.C. 8:31B-4.97) but not reported therein. However, costs of such donated organs are applied as increases to Costs Related to Patient Care and Revenues are applied as offsets (Case B).

(c) Blood: In order to encourage hospital solicitation of blood donations, the purchase cost of whole blood or the equivalent units of blood extender and/or plasma are excluded and treated as Case C.

(d) Provisions of Health Care Services to Another Health Care Facility or Shared Services: Where a hospital care facility utilizes the laboratory, data processing, physical therapy department, or other services of a hospital, such costs are not included in the Costs Related to Patient Care of the hospital providing the services. The associated costs (including overhead) and revenue should be excluded from the definitions of those centers in the providing hospital and are treated as Case B.

(e) Physician Fees Remunerated to a Hospital: Where a physician's compensation arrangement with a hospital requires some or all of the physician's fees received directly from patients to be turned over to the hospital, such fees are not included in Revenue Related to Patient Care and are treated as Case B.

(f) Excluded Ambulatory Services: Outpatient Renal and Home Dialysis. The cost and revenue related to these services are to be treated as Case C. Sufficient accounting records should be maintained to account for the costs of such operations (that is, Medicare cost report HCFA-2552) and such direct and indirect costs shall be excluded from Costs Related to Patient Care.

(g) Excluded Ambulatory Services: HealthStart Maternal Care Health Support Services. The revenues and expenses associated with the provision of these services shall be treated as Case C, netted against each other.

(h) Excluded Ambulatory Services: HealthStart Pediatric Continuity of Care. In Hospitals with salaried pediatricians, revenues and expenses associated with non-institutional Medicaid capitated fee shall be treated as Case C and netted against each other.

(i) Mobile Intensive Care Unit (MICU) Services provided after November 1, 1987: The cost and revenue related to these services are to be treated as Case C, revenues and expenses are netted. Sufficient accounting records should be maintained to account for the costs of such operations (that is, Medicare cost report HCFA-2552) and such direct and indirect cost shall be excluded from Costs Related to Patient Care.

Amended by R.1981 d.10, effective January 9, 1981.
See: 12 N.J.R. 643(d), 13 N.J.R. 92(a).

(a)1 and 2 added.

Amended by R.1987 d.338, effective August 17, 1987.
See: 19 N.J.R. 840(a), 19 N.J.R. 1545(a).

(f) added.

Amended by R.1988 d.213, effective May 16, 1988.
See: 19 N.J.R. 2365(a), 20 N.J.R. 1082(a).

Added (g) and (h).

Amended by R.1989 d.604, effective December 18, 1989.
See: 21 N.J.R. 2453(a), 21 N.J.R. 3970(a).

MICU services provided after November 1, 1987 excluded at (g).
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.63 Education and Research

(a) Approved Education and Research Income such as grants, or contract payments, tuitions and fees received as direct support for approved educational and research programs (with the exception of those from the Graduate Medical Education Program for primary care residency programs in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology) (see N.J.A.C. 8:31B-4.35) are used to offset such expenses and treated as Case B. (Transfers of Specific Purpose Fund Revenues to the Unrestricted Fund are to be reported as nonoperating revenue, below.)

(b) Non-Approved Education and Research (not approved in accordance with N.J.A.C. 8:31B-4.35) costs and revenues up to the amount of such costs are excluded. Overhead expenses should be included in the costs of such program (Case A).

(c) Salaried House Physicians hired by the hospital to supplement house coverage of attending physicians or patient units such as residents of non-hospital programs, are included (Case B). Coverage of emergency services and other ambulatory and ancillary services by such physicians are included in the cost center definition of these services.

8:31B-4.64 Sales and services not related to patient care

(a) Provision of General Services to an External Organization: The provision of data processing, laundry, house-keeping, managerial or other general services by a hospital to an organization other than another health care facility are excluded and treated as Case A. Costs of such arrangements should include associated overhead and be reported in accordance with the reporting of related organizations (see N.J.A.C. 8:31B-4.25).

(b) Sale of Medical Supplies (other than for an episode of hospital care) to patients such as take-home drugs, excluding those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care, and others are excluded. Take-home supplies for renal dialysis and home health care are included where included in the provisions of Medical HIM-29 and HIM-11 (Case A).

(c) Sale of Scrap revenue is excluded from the revenue center and treated as Case B.

(d) Medical Records Transcription for patients, their legal advocates, or other non-hospital personnel are excluded. Costs (to be reported to the revenue received unless direct costing is available) and revenue are treated as Case A.

(e) Cafeteria operations, including vending machines, are treated as Case C, except for the subsidization of employee meals and meals for students in approved programs. Cafeteria operating losses are to be apportioned among employees, students and others per N.J.A.C. 8:31B-4.131. Subsidization of employee (including resident) meals is included as an employee fringe benefit. Subsidization of student meals is included as other direct expenses in either EDU or GME cost centers (see N.J.A.C. 8:31B-4, Part V).

(f) Gift and Coffee Shops revenue and expense (including sales tax expense) as well as other activities which may be supported by volunteers are excluded from Services Related to Patient Care (Case C).

(g) Services Rendered to Staff Physicians by a hospital which normally would be incurred in a physician's private practice, such as the provision of medical secretarial services, are excluded and treated as Case C so long as the physician's compensation is not provided through agreement with a hospital.

(h) Parking lot or parking garage expenses and revenues at the site of the hospital are to be netted and the remainder apportioned between employees and others per N.J.A.C. 8:31B-4.131. The provision of parking facilities to:

1. Employees are included-Losses incurred from the operation of an employee parking lot are included as an employee fringe;

2. Staff physicians parking is included and treated as Case B.

3. Others are included (Case B) if the hospital's charge for parking is not substantially inconsistent with other parking facilities in the community where the hospital is located.

(i) Non-Patient Room and Board expenses and revenues are to be netted and apportioned among employees, students and others per N.J.A.C. 8:31B-4.131. Sufficient accounting records should be maintained to identify all related expenses as well as number of persons housed. The provision of Room and Board to:

1. Employees and residents (including rotating residents who spend some portion of their residency at the hospital) is included. Losses incurred from housing an employee are included as an employee fringe benefit (Case B., N.J.A.C. 8:31B-4.61(a)2).

2. Students are included if in an approved educational program. Losses incurred from housing a student should be assigned to Nursing and Allied Health Education (EDU) and Graduate Medical Education (GME) Case B, N.J.A.C. 8:31B-4.61(a)2 or Non-Approved Education and Research (Case A).

3. Others not involved with the patient services of the hospital are excluded (Case A).

Amended by R.1983 d.596, effective December 19, 1983.

See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(h)3 clarified; cross-reference added to (i)1 and 2.

Amended by R. 1985 d.550, effective November 4, 1985.

See: 17 N.J.R. 2004(a), 17 N.J.R. 2637(a).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.65 Patient convenience items

(a) Television and Radio provided to patients are excluded and net gains or losses from such services are treated as Case C.

(b) Telephone and Telegraph services provided to patients, including the appropriate portion of the hospital's switchboard costs, are excluded and net gains or losses from such services are treated as Case C.

(c) Luxury Meals and Items provided to patients or guests are excluded and treated as Case A.

(d) Non-Patient Room Rental Income generated from boarders related to or visitors of a patient, are excluded from Revenue Related to Patient Care and Treated as Case B.

(e) Private-Duty Nursing Services where provided through the hospital at the request of the patient and not prescribed by the attending physician are excluded and treated as Case C.

(f) Private Room Differential Income above a hospital's most common charge for a semi-private room for similar routine services, when specifically requested by the patient is excluded and treated as Case C. Where ordered by the attending physician for medical necessity, income is excluded and treated as Case C. Hospitals should maintain separate revenue classifications for medically necessary and patient convenience private room revenue.

Amended by R.1984 d.500, effective November 5, 1984.
See: 16 N.J.R. 2326(a), 16 N.J.R. 3019(b).

(f) substantially amended.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.66 Administrative items

(a) Administrative Expense Exclusions as listed in this section are not included in Costs Related to Patient Care and, as such, are not to be included in expenses defined as General Administrative Services (Case C);

1. Life insurance premiums for employees where the hospital is the direct beneficiary;
2. Stockholders servicing costs such as those incurred to schedule and hold annual meetings;
3. Advertising costs, conducted by hospital personnel or agents of the hospital, which are directed at increasing utilization or medical staff membership, except where attempts to increase medical staff membership is for the procurement of a scarce medical service needed in the service area of the hospital;
4. Costs of membership in organizations not related to the development and operation of the hospital and the rendering of patient care services (e.g., social or fraternal organizations) are not included as an employee fringe benefit in N.J.A.C. 8:31B-4.131;
5. Monies paid by a hospital to the home office, corporate or order headquarters for:
 - i. Non-patient care related enterprises;
 - ii. Abandoned home office planning costs for construction of a new facility; or
 - iii. The imputed value of services performed by non-paid workers in the case of religious orders.

(b) Income and Other Taxes including penalties for late payment of taxes (See N.J.A.C. 8:31B-4.34 for full description) are not includable as Costs Related to Patient Care and as such are not to be included in expenses defined as General Administrative Services, N.J.A.C. 8:31B-4.118 (Case C).

(c) Purchase Discounts, revenue from rebates and quantity discounts, are to be reported as expense recoveries.

(d) Gains on pension reversions are included as Services Related to Patient Care and, as such, shall be treated as Case B and offset against Costs Related to Patient Care.

Amended by R.1982 d.449, effective December 20, 1982.

See: 14 N.J.R. 946(b), 14 N.J.R. 1457(a).

Added hospitals "under the conditional accept or not accept options" to (e).

Amended by R.1983 d.596, effective December 19, 1983.

See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(c): "applied as offsets against . . . (Case B)" changed to "reported as expense recoveries".

Amended by R.1986 d.477, effective December 15, 1986 (operative January 1, 1987).

See: 18 N.J.R. 1911(a), 18 N.J.R. 2447(a).

Amended cross reference in (d) to 4.46.

Amended by R.1991 d.158, effective March 18, 1991.

See: 22 N.J.R. 3724(a), 23 N.J.R. 898(a).

Exception to exclusion at (e); treatment of pension gains added at (f).

Amended by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.67 Non-operating revenues (net of expenses)

(a) Income, net of expenses, or Investment in Rental Property to physicians or others is excluded from Revenue Related to Patient Care and treated as Case A.

(b) Income or Investment, net of transaction expense, of Operating Fund are to be applied as offsets against Costs Related to Patient Care and treated as Case B.

(c) Income or Investments, net of transaction expense, of Board Designated Funds are not to be included in Costs Related to Patient Care and are treated as Case C.

(d) Unrestricted Income from Donor Restricted Plant and Endorsement Funds are not to be included in Revenue Related to Patient Care and treated as Case C.

(e) Transfer from Restricted Funds, other than Specified Purpose Funds (i.e., expenditures from principal and interest on gifts which are donor restricted) are not included as Revenue Related to Patient Care and treated as Case C.

(f) Unrestricted Donations, net of Funding Raising Costs, are not to be included as Revenue Related to Patient Care and treated as Case C.

(g) Transfer of Specific Purpose Funds to the Unrestricted Fund and Specific Purpose Grants and other funds received from the Federal Government, New Jersey State Government, New Jersey Heart Association, or other governmental or charitable organizations are offset against Costs Related to Patient Care (with the exception of those from the Graduate Medical Education Program for primary care residency programs in Family Practice, Internal Medicine, Pediatrics or Obstetric/Gynecology). However, grants on behalf of the medically indigent are to be reported as a contra-deducted from Gross Revenue Related to Patient Care (operating). "Seed Money" . . . received with a grant is similarly offset against operating expenses unless this would result in grants being withheld from New Jersey institutions (Case B).

(h) Primary Care Residency Specific Purpose Grants and income from primary care residency specific purpose funds (i.e., grants for the support of LCGME approved residency program in Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology) are not to offset the costs of such programs and treated as Case C.

(i) Interest Income on Trustee-held Funds related to borrowing or loans is a Case B, unless a hospital is prohibited from using the funds to offset current debt service obligations. If the hospital is prohibited from using the funds, the interests and income earned is a Case C until these funds are released for the hospital's benefit.

(j) Interest income from financial charges on delinquent accounts receivable shall not be included in Costs Related to Patient Care. Income shall be treated as a Case C item.

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(i) added.

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Interest on finance charges deleted from (b); (j) added.
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.68 through 8:31B-4.70 (Reserved)

PART V. DEFINITION OF COST AND REVENUE CENTERS

8:31B-4.71 Reporting of cost and revenues

Costs and Revenues Related to Patient Care are to be reported per the following definitions and N.J.A.C. 8:31B-4, Part I, Units of Service are to be reported per N.J.A.C. 8:31B-4.131.

Case Notes

Regulations designed to establish a prospective rate of reimbursement related to measure of hospital resources consumed for each particular illness and identified as a price per case by Diagnosis Related Group; Diagnosis Related Group definition. *Riverside General Hospital v. New Jersey Hospital Rate Setting Commission*, 98 N.J. 458, 487 A.2d 714 (1985).

Diagnosis Related Group regulatory scheme constitutional and not preempted by federal law; preemption discussion; per diem contracts between hospitals and health maintenance organizations (HMO's) not permitted under regulations. *Health Care Plan of New Jersey, Inc. v. Schweiker*, 553 F.Supp. 440 (D.N.J.1982), affirmed 707 F.2d 1391 (3rd Cr.1983), certiorari denied 104 S.Ct. 71, 464 U.S. 815, 78 L.Ed.2d 84 (1983).

Former N.J.A.C. 8:31B-3.12 established Diagnosis Related Group (DRG) method of cost reimbursement. In re: *Barnet Memorial Hospital Rates*, 92 N.J. 31 455 A.2d 469 (1983).

8:31B-4.72 Medical-Surgical Acute Care Units (MSA)

(a) Function:

1. Medical-Surgical Acute Care Units provide care to patients on the basis of physicians' orders and approved nursing care plans. Medical-Surgical Acute should include the cost and revenue associated with services to all patients treated in beds normally designated as Medical-Surgical, regardless of the clinical specialty of attending physicians or age of the patient. Include the cost and revenue of beds designated as definitive observation or intermediate care (i.e., "step down") beds.

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported here, and also as a reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

3. Functions include serving and feeding of patients; collecting sputum, urine; and feces samples; monitoring of vital life sign; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids, answering to patients' call signals; and keeping patients' room (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.73 Obstetric Acute Care Unit (OBS)

(a) Function:

1. The provision of care to the mother before, during and following delivery on the basis of physicians' orders and approved nursing care plans is provided in the Obstetric Acute Care Unit. Obstetrics may include services to clean gynecological patients treated in beds licensed by the Department of Health as obstetrics.

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported as a reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

3. Functions include instructing of mothers in postnatal care and care of the newborn; feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assistance of physician in changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction of drugs; administering specified medication; infusing I.V. fluids; answering of patients' call signals; and keeping patients' room (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) Patient Days.

8:31B-4.74 Pediatric Acute Care Units (PED)

(a) Function:

1. Pediatric Acute Care Units provide care to Pediatric patients (normally children less than 14 years and including, "boarder patients") in Pediatric nursing units on the basis of physicians' orders and approved nursing care plans. Pediatric Acute should include the costs and revenues associated with all patients, regardless of age, treated on units normally reserved for the care of patients less than 14 years of age and does not include the costs and revenues of treating patients less than 14 years in Medical-Surgical and Psychiatric Acute Units. Cost and Revenue associated with swing beds (i.e., those not designated exclusively for one type of patient) are to be apportioned among the appropriate Routine Service Centers as defined herein based on actual utilization.

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported as a reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

3. Functions include serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids; answering of patients' call signals; and keeping patients' rooms (personal effects) in order.

(b) Units of service: Patients (Admissions and Transfers In) and Patient Days.

8:31B-4.75 Psychiatric Acute Care Units (PSA)

(a) Function:

1. Psychiatric Acute Care Units provide care to patients admitted for diagnosis as well as treatment on the basis of physicians' orders and approved nursing care plans. The units are staffed with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons. Psychiatric Acute should include only the costs and revenues associated with services to psychiatric patients in a unit solely designated to the care of the acute mentally ill.

2. All revenues generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported as a

reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55. Special Service consumed by patients on Psychiatric Acute Care Units are to be reported in the Psychiatric/Psychological Services Center.

3. Functions include serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of bed; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids; answering of patients' call signals; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

8:31B-4.76 Burn Care Unit (BCU/ICU)

(a) Function:

1. Burn Care units provide care to severely burned patients that are of a more intensive nature than the usual acute nursing care provided in medical surgical units. Burn units are staffed with specially trained nursing personnel and contain specialized support equipment for burn patients who require intensified, comprehensive observation and care. Burn Care Units should include only the costs and revenues associated with services to burn patients in a unit solely designated for this purpose. Burn patients not in a unit solely designated for this purpose, should be reported in Intensive Care.

2. Functions include serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids; answering of patients' call signal; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.77 Intensive Care Units (ICU/BCU)

(a) Function:

1. Intensive Care Units provide nursing care to patients who, because of surgery, shock, trauma, serious injury or life threatening conditions, require intensified comprehensive observation and care. These units are staffed with specially trained nursing personnel and contain specialized equipment for patient monitoring and life support systems. Intensive Care Units include Stroke Care, Pediatric, Intensive Care, Burn Care Unit (BCU), Medical and Surgical Intensive Care and mixed Intensive Care-Coronary Care Units, but exclude units solely designated 25 Coronary Care Units or Neo-Natal Intensive Care Units. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include monitoring patients' progress; operating specialized equipment; assisting physicians during examinations and treatments; dispensing prescribed medication, including I.V. solutions, cleansing and dressing incisions and wounds; maintaining patients' charts; and requisitioning and storing medical supplies and drugs kept in these units.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.78 Coronary Care Units (CCU)

(a) Function:

1. Coronary Care Units provide the delivery of care of a more specialized nature than that provided to the usual Medical, Surgical, and Pediatric patient. The unit contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open heart surgery or life threatening conditions, require intensified, comprehensive observation and care and is staffed with specially trained nursing personnel. Coronary patients treated in mixed Intensive/Coronary Care Units should be included in the Intensive Care Units (ICU) center. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include serving and feeding of patients; collecting of sputum, urine and feces samples; monitoring of vital life signs; operating of specialized equipment related to this function; preparing of equipment and assisting of physicians during patient examination and treatment; changing of dressings and cleansing of wounds and incisions; observing and recording emotional stability of patients; assisting in bathing patients and helping into and out of beds; observing patients for reaction to drugs; administering specified medication; infusing I.V. fluids; answering of patients' call signal; and keeping patients' rooms (personal effects) in order.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

8:31B-4.79 Neo-Natal Intensive Care Unit (NNI)

(a) Function:

1. A Neo-Natal Intensive Care Unit provides care to newborn infants that is of a more intensive nature than care provided in Pediatric Acute or Newborn Nursing units. Care is provided on the basis of physicians' orders and approved nursing care plans. The units are staffed with specially trained nursing personnel and contain specialized support equipment for treatment of those newborn infants who require intensified, comprehensive observation and care. Neo-Natal Intensive Care Units are designated perinatal centers by the Department of Health, Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include feeding infants; collecting sputum, urine and feces samples; monitoring of vital life signs; operating specialized equipment needed for this function; preparing equipment and assisting physicians during infant examination and treatment; changing dressings and cleansing wounds and incisions; bathing infants; observing patients for reactions to drugs and administering specified medication; and infusing I.V. fluids.

(b) Units of Service: Patients (Admissions and Transfers In) and Patient Days.

8:31B-4.80 Newborn Nursery (NBN)

(a) Function:

1. Newborn Nursery provides nursing care to newborns on the basis of pediatricians' orders and approved nursing care plans. Newborn Nursery should include all normal care newborns. Bassinets maintained for infants other than newborn (pediatrics) should be included here. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include constant observation of newborns; checking on progress of newborns; feeding and diapering newborns; assisting pediatricians during examination and treatment; operating special equipment; dispensing prescribed medication; and educating new mothers on infant care; maintaining newborns' charts; requisitioning and sorting medical supplies; drugs and infants formulae; and scheduling newborns for ancillary services.

3. Costs associated with units designated by the Department of Health as perinatal centers should be reported in this cost center.

(b) Units of Service: Patient and Patient Days (counted comparably with non-newborn patients).

8:31B-4.81 Emergency Services (EMR)

(a) Function:

1. Emergency Services provide emergency treatment to sick and injured patients requiring medical care on an immediate, unscheduled basis. Also included are non-emergency type patients who request outpatient treatment on an unscheduled basis in the Emergency Room.

2. Functions include assisting critical patients to and from vehicles; expediting treatment for critical patients for ancillary services; coordinating emergency admissions; operation of an ambulance; operation of cast room; assisting physicians in emergency treatment; cleaning and dressing wounds; applying casts; maintaining aseptic conditions; monitoring of vital life signs.

(b) Units of Service: Visits.

8:31B-4.82 Clinics (CLN)

(a) Function:

1. Clinics provide organized non-emergency diagnostic, preventive, curative, rehabilitative and educational services on a primarily scheduled basis to ambulatory patients, including those referred by private physicians.

2. This center should include the costs and revenues associated with operating organized clinics for all purposes. Examples of organized clinics include Alcoholism, Dental, Diagnostic, Diabetes, Drug Abuse, Employee Health, ENT, Health Centers, General Clinic, Guidance Counseling, Obstetrics/Gynecology, Ophthalmology, Pediatrics, Physical Medicine, Psychiatric Day Care and Speech. The costs and revenues associated with an organized Ambulatory Renal Dialysis Unit should be reported in the Dialysis (DIA) center. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55. The cost and revenue of operating clinics that are a branch of the institution are included in Clinics.

3. Functions include assisting physicians in treatments and examinations; health guidance and counseling; scheduling and arranging for other hospital services for patient; referring ambulatory patients requiring prolonged or specialized care to appropriate services; and participating in community activities designed to promote health education.

(b) Units of Service: Visits.

8:31B-4.83 Home Health Agency (HHA)

(a) Function:

A Home Health Agency provides care to patients normally at their place of residence in accordance with the definitions of services contained in Medicare HIM-11. Expenses and Revenues of ancillary services performed at homes of patients serviced under a home health program should be reported in the appropriate ancillary service center.

(b) Units of Service: Home Health Visits.

8:31B-4.84 (Reserved)

8:31B-4.85 Anesthesiology (ANS)

(a) Function:

1. Anesthesiology is a hospital based service conducted under the direction of either a qualified physician trained in anesthesiology (i.e., an anesthesiologist) or the operating surgeon.

2. Anesthesia gases and other anesthesia supplies and minor moveable equipment if not individually charged to the patient are to be reported in Anesthesiology. The costs of anesthesiologists' compensation and any other costs associated with anesthesiologists' practice (i.e., employees of the physician, supplies the physician purchases through their private practice, etc.), as well as the revenue generated by the anesthesiologist and anyone under the physician's employment, are to be reported to the extent that the anesthesiologists' compensation is provided through agreement with the hospital. Cost associated with nurse anesthetists employed by the hospital are also to be reported here.

3. Functions include obtaining laboratory findings and patient's anesthetic history prior to administration of anesthetics; administering anesthetics; recording kind and amount of anesthetic administered; observing patient's condition until all effects of anesthesia have passed; accompanying patient to recovery room or intensive care unit; administering treatment to patients having symptoms of post anesthetic complication; prescribing pre-and post-anesthesia medications; and carrying out safeguards for administration of anesthetics.

(b) Units of Services: Anesthesia Minutes.

8:31B-4.86 Cardiac Catheterization (CCA)

(a) Function:

1. Cardiac Catheterization includes all invasive cardiac diagnostic procedures performed in dedicated or non-dedicated cardiac catheterization or coronary angiographic laboratories. Cardiac catheterization procedures are performed in a limited number of hospitals that are designated as cardiac diagnostic facilities or regional cardiac surgical centers. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include preparation of patients for testing; explaining test procedures to patients; inspecting, testing and maintaining special equipment; and achieving optimal quality physiological and coronary angiographic studies.

(b) Units of Services: Procedures.

8:31B-4.87 Delivery and Labor Rooms (DEL)

(a) Function:

1. Delivery and Labor Rooms provide nursing care by specially trained personnel to obstetrical patients and patients having gynecological procedures performed in the Delivery Suite. Cesarean sections are to be included if they are performed in a delivery room. Costs of routine housekeeping functions (i.e., those conducted throughout the hospital) performed by delivery and labor personnel are to be included in the Housekeeping center—only specialized clean-up procedures unique to Delivery and Labor Rooms functions are to be included in Delivery and Labor. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. Functions include maintaining aseptic conditions; enforcing of safety rules and standards; arranging sterile setup for deliveries; monitoring patient and caring for patient's needs while in labor and in recovery; transporting patients within the labor and delivery suite; preparing for delivery; comforting the patient during delivery; assisting the physician during delivery; fetal heart monitoring; amniocentesis (if performed in the delivery suite); circumcision of male newborns; and cleaning up after delivery to the extent of preparation for pickup and disposal of used linen, instruments, utensils and waste.

(b) Units of Services:

1. Deliveries;
2. Gynecological Procedures.

8:31B-4.88 Dialysis (DIA)

(a) Function: Dialysis is a hospital based service employing the use of an artificial kidney machine for cleansing the blood. Dialysis includes both hemodialysis and peritoneal dialysis procedures. The inclusion of Dialysis take-home supplies, if not individually charged, and other costs and revenues is in accordance with Medicare HIM 29 instructions. Dialysis take-home and other supplies individually charged for are to be reported in Medical and Surgical Supplies Sold, whether sold or rented, if such supplies are included per Medicare HIM 29.

(b) Units of Service: Treatments.

8:31B-4.89 Drugs Sold to Patients (DRU)¹

(a) Function:

1. The Drugs Sold to Patients center is used for the accumulation of the invoice cost and corresponding revenue of all pharmaceuticals and intravenous solutions individually charged to patients including chemotherapy drugs. The invoice/inventory cost of non-charged (pharmaceuticals) or I.V. solutions issued by the Pharmacy to other centers shall be transferred to the using centers, preferably on a monthly basis. If such items are sold in other centers, the cost of those items must be transferred to this center. The overhead cost of preparing and issuing drugs and I.V. solutions sold directly to patients must be accumulated in the Pharmacy center.

2. Medically prescribed food supplements, if charged directly to patients are included in Drugs Sold to Patients. Cost and revenue associated with blood (i.e., whole blood and packed red cells) and blood components (i.e., fibrinogen, gamma globulin) are to be excluded from the Laboratory center and reported as a reconciliation per N.J.A.C. 8:31B-4, Part IV and N.J.A.C. 8:31B-4.91. Excluded from this center are the cost and revenue associated with drugs furnished to a patient for use after his episode of hospital care (except for those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care). Included in the center are the cost and revenue associated with drugs and I.V. solutions sold under renal dialysis and home health agency programs as specified in Medicare HIM 29 and HIM 11.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.466 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow Drugs and I.V. solutions to be reported in accordance with SHARE definitions.

8:31B-4.90 Electrocardiology (EKG)¹

(a) Function:

1. Electrocardiology is a hospital service that utilizes specialized electrical equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments under the direction of a qualified physician. The cost incurred and revenue generated by personnel or equipment for electrocardiology procedures continuously available as part of the functions of other centers (i.e., Intensive or Coronary Care Units, Operating and Recovery Rooms, Diagnostic Radiology, and Cardiac Catheterization) should be included in those centers.

2. The cost of cardiologists' compensation as well as the revenue generated by cardiologists are to be reported to the extent that the cardiologists' compensation is provided through agreement with the hospital.

3. Functions include wheeling portable equipment to patient's bedside; conducting stress tests; explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing and maintaining special equipment; and attaching and removing electrodes from patients.

(b) Units of Service: Electrocardiograms.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow Drugs and I.V. solutions to be reported in accordance with SHARE definitions.

8:31B-4.91 Laboratory

(a) Function:

1. Laboratory is normally a hospital based pathological or clinical service conducted under the direction of a qualified pathologist. All laboratory operations, including subsidiary laboratories of the hospital, should be included here, whether purchased from outside or performed by the hospital laboratory. Services provided for outside institutions are to be excluded and reported as a reconciliation per N.J.A.C. 8:31B-4, Part IV. Include all fields of laboratory work, such as Autopsy, Blood Bank, Chemistry, Cytology, Hematology, Histology, Immunology, and Microbiology. Included are laboratory work in poison and infection control, epidemiology (including nursing epidemiology work), and coagulation testing. Infection control officer costs not related to laboratory work should be apportioned to benefiting patient care areas. The revenue and cost of performing blood gas analyses are to be included in the Respiratory Therapy center, and pathologist compensation costs and revenues related to Nuclear Medicine should be included in that center.

2. The procuring (drawing), receiving, storing, typing and crossmatching of whole blood, blood components and blood products should be included in Laboratory. Purchase cost of and patient payments for blood and blood products are to be excluded and reported per Instructions in N.J.A.C. 8:31B-4, Part IV. The costs associated with procuring blood donations are to be included in Laboratory, but payments to donors are to be excluded and reported as a reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV.

(b) Units of Service: College of American Pathologists Relative Value Units.

8:31B-4.92 Medical and Surgical Supplies Sold (MSS)

(a) Function:

1. The Medical and Surgical Supplies Sold center is used for the accumulation of the invoice cost and revenue of all medical and surgical supplies and equipment sold or rented directly to patients. The invoice/inventory cost of non-charged supplies and equipment issued by the Central Supply Service center to other centers shall be transferred to the using centers, preferably on a monthly basis. If such items are sold in other hospital centers, the cost and revenue of those items must be transferred to this center. The overhead cost of preparing and issuing medical and surgical supplies and equipment sold or rented directly to patients must be accumulated in the Central Supply Services center.

2. Excluded from this center are the cost and revenue associated with supplies furnished to a patient for use after his episode of hospital care (except for those items where it would be medically unreasonable to limit the patient's use to the episode of hospital care, e.g., pacemakers, permanent prostheses, etc., and take-home Dialysis and Home Health Agency supplies included per Medicare HIM 29 and HIM 11.) Rather, the costs and

revenues associated with such items are to be reported as reconciliations per instructions in N.J.A.C. 8:31B-4, Part IV.

8:31B-4.93 Neurology, Diagnostic (NEU)¹

(a) Function:

1. This center provides diagnostic neurology services such as electroencephalography and electromyography under the direction of a qualified physician. Specialized equipment is used to record electromotive variations in brain waves and to record electrical potential variation for diagnosis of muscular and nervous disorders.

2. The cost of compensation of physicians involved in diagnostic neurology as well as the revenue generated by these physicians for their activities are to be reported to the extent that their compensation is provided through agreement with the hospital.

3. Functions include wheeling portable equipment to patient's bedside; explaining test procedures to patient; operating specialized equipment; inspecting, testing and maintaining special equipment; and attaching and removing electrodes from patients.

(b) Units of Service:

1. EEGS;
2. EMGs.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.94 Nuclear Medicine (NMD)

(a) Function:

1. Nuclear Medicine is a hospital based service which provides diagnosis and treatment of patients by injectible or ingestible radioactive isotopes under the direction of a qualified physician.

2. Costs shared with Therapeutic Radiology, Diagnostic Radiology, and Laboratory, such as radiologists, pathologists, radiology office expense and maintenance costs should be apportioned among the benefiting centers. The cost of compensation of physicians involved in Nuclear Medicine, as well as the revenue they generate, are to be reported to the extent that their compensation is provided through agreement with the hospital.

3. Functions include consultation with patient and attending physician; radioactive waste disposal; and storage of radioactive materials.

(b) Units of Service: Procedures.

8:31B-4.95 Occupational and Recreational Therapy (OCC)¹

(a) Function:

1. Occupational therapy is the application of purposeful, goal-oriented activity, under the direction of a registered therapist and medical director, in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health.

2. Recreational Therapy is the employment of sports, dramatics, arts and other recreational programs, under the direction of a registered therapist and medical director to stimulate the patient's recovery rate.

3. The cost of compensation of physicians involved in occupational and recreational therapy as well as the revenue generated by these physicians for their activities are to be reported to the extent that their compensation is provided through agreement with the hospital.

4. Functions include education and training in activities of daily living (ADL); the design, fabrication, and application of splints; sensorimotor activities; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaption of physical environments for the handicapped; continuing and organizing instrumental and vocal musical activities; and directing activities of volunteers in respect to these functions. These services are provided to individuals or groups.

(b) Units of Service: Visits.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.96 Operating and Recovery Rooms (ORR)

(a) Function:

1. Operating and Recovery Rooms provide surgical services to both inpatients and outpatients. These rooms are staffed with specially trained personnel who assist the surgeon during operations and the patient immediately thereafter. Cost of and revenue from rooms used for minor and ambulatory surgery or special procedures (e.g., cystoscopy, endoscopy, gastroscopy) other than a surgical clinic should be included here. Also included are the cost and revenue associated with surgical dental services provided to patients.

2. Costs of routine housekeeping functions (i.e., those conducted throughout the hospital) performed by Operating and Recovery Room personnel are to be reported in the Housekeeping center. Only the cost of specialized cleaning procedures unique to Operating and Recovery Rooms and performed by Operating and Recovery Room personnel are to be reported in the Operating and Recovery Room Center. Medical and Surgical Supplies are to be reported per N.J.A.C. 8:31B-4.55.

3. Functions include the requisitioning of instruments, utensils, medical supplies, and drugs required for surgery; inspecting, testing and maintaining specialized surgical equipment; maintaining aseptic techniques; enforcing of safety rules and standards; assisting in preparing patients for surgery (only while in the O.R.; exclude prep work done on patient floors); assisting the surgeon during operations; counting of sponges, needles and instruments used during operations; preparing patients for transportation to recovery room; monitoring patient and caring for patient's needs while recovering from anesthesia; and pickup and disposal of used linen, instruments, utensils and waste.

(b) Units of Service:

1. Procedures;
2. Minutes.

8:31B-4.97 Organ Acquisition (ORG)¹

(a) Function:

1. This center acquires, stores, and preserves all kidneys and other human organs for their eventual transplantation to patients of the hospital. All direct costs incurred by the Laboratory, Operating and Recovery Rooms and other hospital departments in acquiring organs are to be transferred to the Organ Acquisition Center. The costs and revenues (or value of credits) of acquiring organs for a pool or for transplantation to a patient of another hospital should be reported as an organ donation reconciliation per N.J.A.C. 8:31B-4, Part IV.

2. Functions include conducting sterile autopsies to obtain organs; purchasing of organs from a central pool; harvesting; and preservation of organs.

(b) Units of Service: Transplants.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.98 Physical Therapy (PHT)

(a) Function:

1. Physical Therapy is a service employing therapeutic exercises and massage, and utilizing effective properties of light, heat, cold, water, and electricity in diagnosis and rehabilitation of patients with neuromuscular, orthopedic, and other disabilities under the medical direction of a physiatrist or other qualified physician. Physical Therapy services include the provision of clinical and constructive services and the direction of patients in the use, function, and care of braces, artificial limbs, and other devices. This center includes the cost of physical therapy related medical supplies, materials and equipment not requisitioned from Central Supply Services and for which a separate charge is not made to a patient.

2. The cost of all supplies and equipment furnished to a patient for use after his episode of hospital care (e.g., crutches, elastic bandages, etc.) but excluding items where it would be medically unreasonable to limit the patient's use of the item to his episode of hospital care (e.g., customized braces, prostheses, etc.) is to be excluded from this center and is to be reported as per N.J.A.C. 8:31B-4, Part IV.

3. Functions include prescription of therapeutic exercises; counseling of patients and relatives; organizing and conducting medically-prescribed physical therapy programs; application of diagnostic muscle tests; administration of whirlpool and compact baths; changing of linen on beds and treatment tables; and assisting patients in changing clothes.

(b) Units of Service: Visits.

Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

8:31B-4.99 Psychiatric/Psychological Services (PSY)¹

(a) Function:

1. This center provides psychiatric and psychological services such as individual, group, and family therapy to adults, adolescents and families of hospital patients, but excluding costs and revenues associated with psychiatric/psychological clinic visits. Costs and revenues to be reported here include those related to the compensation of psychiatrists, psychologists, or psychiatric social workers to the extent that such compensation is provided through agreement with the hospital.

2. Functions include evaluation and psychotherapy to inpatients; emergency room psychiatric/psychological care; biofeedback training; psychological testing; and shock therapy.

(b) Units of Service: Hours (spent with patients).

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.100 Radiology, Diagnostic (RAD)

(a) Function:

1. Diagnostic Radiology is normally a hospital based service conducted under the direction of a qualified radiologist, and includes procedures such as angiograms (except coronary angiograms), arteriograms, computerized axial tomography scans, and echograms (ultrasonography).

2. Cost shared with Therapeutic Radiology and Nuclear Medicine such as radiologists, radiology office expense and maintenance costs should be apportioned among the benefiting cost centers. The salaries of personnel such as bioengineers, assigned substantially full-time for the purpose of maintaining, testing and inspecting Diagnostic Radiology equipment are to be reported here.

3. The cost of compensation of radiologists as well as the revenue they generate are to be reported in this center to the extent that their compensation is provided through agreement with the hospital.

4. Functions include taking, processing, examining and interpretation of radiographs and fluorographs; consultation with patient and attending physicians; storage of radioactive materials; and radioactive waste disposal.

(b) Units of Service: California Medical Association Relative Value Units.

8:31B-4.101 Respiratory Therapy (RSP)

(a) Function:

1. Respiratory Therapy is a hospital based service for diagnosis and treatment of pulmonary diseases. This includes pulmonary function testing, the administration of oxygen and certain potent drugs through inhalation or positive pressure, and other forms of rehabilitative therapy, under the direction of a qualified physician. Pulmonary function testing is the testing and thorough measurement of inhaled and exhaled gases and analysis of blood, and evaluation of the patient's ability to exchange oxygen and other gases.

2. The cost of compensation of pulmonary physicians involved in rendering respiratory diagnostic and therapeutic services as well as the revenue generated by these physicians for such activities, are to be reported to the extent that these physicians' compensation is provided through agreement with the hospital.

3. Included in this center are the costs of and revenue generated from all gases administered to patients, excluding the costs and revenue associated with gases administered as part of the anesthetizing process which are included in the Anesthesiology Center.

4. Functions include transporting therapy equipment to patient's bedside; setting up and operating various types of oxygen and other therapeutic gas and mist inhala-

tion equipment; blood gas testing; observing and instructing patients during therapy; visiting all assigned respiratory cases to insure that physicians' orders are being carried out; inspecting and testing equipment; and enforcing safety rules.

(b) Units of Service: Treatments.

8:31B-4.102 Speech Pathology and Audiology (SPA)¹

(a) Function:

1. Speech Pathology provides therapeutic treatment for disorders of production, reception and perception of speech and language. Audiology provides and coordinates services to persons with impaired peripheral and/or central auditory function. This includes the detection and management of any existing communicating handicaps centering in whole or in part on the hearing function. Such activities are coordinated with medical evaluation and treatment of hospital patients.

2. Functions include audiologic assessment (including basic audiometric testing and screening, examination for site of lesions nonorganic hearing loss and various parameters of auditory processing abilities essential for communication function); hearing aid evaluation, selection, orientation, adjustment and other technical related services; audiologic habilitation and rehabilitation including the development, remediation or conservation of receptive and expressing language abilities; demonstrating and evaluating amplification devices and altering systems; evaluating excessively noisy environments; determining through interviews and special tests the etiology, history and severity of speech disorders; and special speech, hearing and language remedial procedures, counseling and guidance.

(b) Units of Service: Visits.

¹In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.103 Therapeutic Radiology (THR)

(a) Function:

1. Therapeutic Radiology is a hospital based service providing therapy by radium and other radioactive substances, including cobalt therapy and linear accelerator treatment, under the direction of a qualified radiologist.

2. Costs shared with Diagnostic Radiology and Nuclear Medicine, such as radiologists, radiology office expense and maintenance costs including salaries of bioengineering personnel, should be apportioned among the benefiting centers.

3. The cost of compensation of radiologists involved in therapeutic radiology as well as the revenue they generate are to be reported to the extent that their compensation is provided through agreement with the hospital.

4. Functions include consultation with patient and attending physician; operation of specialized equipment; storage of radioactive material; disposal of radioactive waste; and inspecting, testing and maintaining specialized equipment.

(b) Units of Service: Procedures.

8:31B-4.104 Central Supply Services (CSS)

(a) Function:

1. Central Supply Services prepares and issues medical and surgical supplies and equipment, except pharmaceuticals and I.V. solutions, to patients and to other cost centers.

2. The invoice cost of non-charged supplies and equipment issued to other centers shall be transferred to the using centers, preferably on a monthly basis. The invoice cost of charged medical supplies shall be transferred to the Medical and Surgical Supplies Sold center, preferably on a monthly basis.

3. The cost of non-charged reusable medical supplies and equipment requisitioned from CSS by different centers (e.g., respirators) are to be reported in the Central Supply Service center. Costs associated with non-charged reusable medical supplies and equipment requisitioned from only one center are to be reported in that center.

4. Functions include requisitioning and issuing of appropriate supply items required for patient care; preparing sterile irrigating solutions; collecting, assembling, sterilizing, and redistributing reusable items; and cleaning, assembling, maintaining, and issuing portable apparatuses.

(b) Statistics: Costed Requisitions of All Medical and Surgical Supplies.

8:31B-4.105 (Reserved)

8:31B-4.106 Dietary (DTY)

(a) Function:

1. Dietary is responsible for the procurement, storage, processing of food, delivery and collection of trays and nourishment to nursing units or outpatient centers. Costs of delivery of trays to the patient once trays have been prepared or have arrived at the nursing unit should be reported in the appropriate Routine Service center. The cost of preparing meals for cafeterias, residents, students, visitors, or house physicians should be reported as per N.J.A.C. 8:31B-4.62 through 4.66 and N.J.A.C. 8:31B-4.131 for luxury and guest meals per N.J.A.C. 8:31B-4.62 through 4.66 and N.J.A.C. 8:31B-4.131. Cost and Revenue of food supplements where charged to patients should be reported in the Drugs Sold to Patients center.

2. Functions include preparing diet manuals; recommending diets; preparing selective menus for various diet requirements; recording diet history; nutrition counseling; determining patient food preferences as to type and method of preparation; food storage and preparations; transportation of food trays to and from nursing units; stocking formula room; cashiering; dishwashing; and maintaining sanitary standards in all facilities.

(b) Statistics: Meals.

8:31B-4.107 Housekeeping (HKP)

(a) Functions:

1. Housekeeping is responsible for the maintenance of a clean and sanitary environment in the institution. The cost of routine cleansing of all areas, excluding Dietary (DTY) and Boiler Room (RPM) should be included in Housekeeping. The cost of housekeeping to non-acute care areas N.J.A.C. 8:31B-4.62 through 4.66 gift and coffee shops, N.J.A.C. 8:31B-4.62 through 4.66 offices rented or maintained for fund raising, N.J.A.C. 8:31B-4.67 or non-approved education N.J.A.C. 8:31B-4.62 through 4.66, and research programs N.J.A.C. 8:31B-4.64(b), and for the room and board of employees, students, or others N.J.A.C. 8:31B-4.62 through 4.66, as well as the expense and revenue of providing housekeeping to entities outside of the hospital N.J.A.C. 8:31B-4.62 through 4.66 should not be reported here, but should be reported per N.J.A.C. 8:31B-4.131. Specialized clean-up activities associated with direct care of patients in nursing units and outpatient and ancillary centers should be reported in those centers.

2. Functions include maid service; janitorial service; transporting trash to plant staging areas; mopping, stripping and waxing floors; washing of walls, ceilings, partitions and windows (inside and outside); stripping, disinfecting and making beds; and moving furniture and fixtures.

(b) Statistics: Hours of Services.

8:31B-4.108 Laundry and Linen (L & L)

(a) Function: Laundry and Linen is responsible for the requisitioning, laundering, distribution, control and mending of linen, bedding, wearing apparel, and disposable linen substitutes used by the institution. The purchased cost and maintenance of all wearing apparel, as well as all linen, bedding, etc. are included. The cost of providing laundry and linen services to non-acute care units (see N.J.A.C. 8:31B-4.62 through 4.66) and for the room and board of employees, students, and others (N.J.A.C. 8:31B-4.62 through 4.66) should not be included in this center but reported N.J.A.C. 8:31B-4.131.

(b) Statistics: Pounds of Laundry

8:31B-4.109 Medical Records (MRD)

(a) Function:

1. Medical Records is responsible for creating and maintaining a medical record for all patients and for maintaining a tumor registry in accordance with Department of Health requirements. The revenue and cost associated with medical records transcriptions for persons outside of the hospital should be reported as reconciliations per N.J.A.C. 8:31B-4.62 through 4.66.

2. Functions include coding; typing; abstracting; filing; indexing; accessing; preparation of birth and death certificates; processing of court and other types of inquiries; maintenance and reporting of data such as patient days, visits, ancillary services and statistics by patient, disease, physician and operation; and coordinating the flow of statistics with certain hospital stations.

(b) Statistics: Percentage of Time Spent.

8:31B-4.110 Pharmacy (PHM)

(a) Function:

1. The Pharmacy procures, preserves, stores, compounds, manufactures, packages, controls, assays, dispenses, and distributes medications (including I.V. solutions) for inpatients and outpatients under the jurisdiction of a licensed pharmacist. Pharmacy services include the maintaining of separate stocks of commonly used items in designated areas.

2. The invoice cost of non-charged pharmaceuticals issued to other cost centers shall be transferred to the using cost centers, preferably on a monthly basis. The invoice cost of charged pharmaceuticals and I.V. solutions shall be transferred to the Drugs Sold to Patients center, preferably on a monthly basis.

3. Functions include development and maintenance of formulary(ies) established by the medical staff and consultation and advice to medical staff and nursing staff on drug therapy; adding drugs to I.V. solutions; determining incompatibility of drug combinations; and stocking of floor drugs and dispensing machines.

(b) Statistics: Costed Requisition of All Drugs.

8:31B-4.111 Social Services (SOC) ¹

(a) Function:

1. Social Services obtains, analyzes, interprets social and economic information to assist in diagnosis, treatment and rehabilitation of patients. These services include counseling of staff and patients in case units and group units; participation in development of community social and health programs and community education. Revenues received by hospitals should not be reported here, but should be reported with the routine or ambulatory

revenue centers where social services were provided and billed for.

2. Functions include interviewing of patients and relatives to obtain a social history relevant to medical problems and planning; interpreting problems of social situations as they relate to medical condition and/or hospitalization; arranging for post discharge care of chronically ill; collecting and revising information on community health and welfare resources.

(b) Statistics: Percentage of Time Spent.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.112 through 8:31B-4.114 (Reserved)

8:31B-4.115 Research (RSH)¹

(a) Function:

This center administers, manages, and carries on research projects of the National Institutes of Health or other projects approved by the Commission. Approved research should be reported per instructions in N.J.A.C. 8:31B-4.62 through 4.66. Separate accounting should be maintained for each research activity in accordance with relevant contracts, grant agreements, or because of restrictions made on donations. Revenue received for research activities such as specific purpose grants should be recorded as reconciliations per instructions in N.J.A.C. 8:31B-4.62 through 4.66. This center includes expenses related to fellowships.

¹ In order to simplify hospital reporting requirements and to allow both SHARE S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.116 Nursing and Allied Health Education (EDU)¹

(a) Function:

1. The Nursing and Allied Health Education Center provides organized programs, approved by an organization which recognizes the professional statute of health services educational programs at the national level, of nursing and medical related clinical education other than for physicians. Hospitals may either operate a school or provide the clinical training activities where a degree is issued by a college or university.

2. Included here are expenses related to the upkeep of student rooms and dormitories. Related revenue such as tuition and grants should be reported per instructions in N.J.A.C. 8:31B-4.62 through 4.66 and non-approved education costs and revenue should be reported per instructions in N.J.A.C. 8:31B-4.62 through 4.66.

3. Functions include selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and educational problems; selecting faculty personnel, assigning and supervising students in giving medical or nursing care to selected patients; and administering aptitude and other tests for counseling and selection purposes.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the cost in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.117 Graduate Medical Education (GME)¹

(a) Function:

1. Graduate Medical Education provides an organized program of graduate medical clinical education to interns and residents. To be approved, a medical residency training program must be approved by the Liaison Committee on Graduate Medical Education or, in the case of osteopathic residencies, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. Residency programs in the field of dentistry in a hospital must have the approval of the Council on Dental Education of the American Dental Association. Included here are expenses related to the office of the Director of Medical Education and the housing and board of residents. Non-approved education costs and revenue should be reported per instructions in N.J.A.C. 8:31B-4.62 through 4.66. Expenses associated with fellowships are to be included in the Research (RSH) center.

2. Functions include selecting qualified students, providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and education problems; and assigning and supervising students.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the cost in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

Case Notes

Hospital Rate Setting Commission erred in refusing to allow hospital to recalculate number of full-time equivalent residents and residents' salaries based on accepted standard. *St. Barnabas Medical Center v. New Jersey Hospital Rate Setting Commission*, 214 N.J.Super. 599, 520 A.2d 805 (App.Div.1987).

8:31B-4.118 General Administrative Services (GAM)¹

(a) Function:

1. General Administrative Services are those services associated with the overall direction and administration of the institution at all levels that are not readily distinguishable between inpatient and outpatient. Expenses and revenues directly associable with services not related to patient care (e.g., data processing services sold to outside organizations administrative personnel responsible for the operation of skilled nursing facilities, and other exclusions) should be reported as reconciliations per N.J.A.C. 8:31B-4.62 through 4.66. Detailed reporting of certain Administrative Service expenses should be provided per N.J.A.C. 8:31B-4.131.

2. General Administrative Services include:

- i. Governing Board;
- ii. Office of Hospital Administrator Medical Administration;
- iii. Medical Administration;
- iv. Nursing Administration (persons responsible for more than one functional center);
- v. Personnel;
- vi. Public Relations;
- vii. Communications;
- viii. Management Engineering;
- ix. Health Sciences Library;
- x. Auxiliary Groups;
- xi. Data Processing;
- xii. Purchasing and Stores;
- xiii. Internal Audit;
- xiv. Postage;
- xv. Medical Library;
- xvi. Medical Photography and Illustration;
- xvii. Licenses and Taxes (other than income taxes and payroll taxes);
- xviii. Insurance (other than Malpractice and Employees Fringe Benefits);
- xix. Security;
- xx. Planning;
- xxi. Professional Association Memberships;

- xxii. Legal and Audit Fees;
- xxiii. Duplicating and Printing;
- xxiv. Financial Administration;
- xxv. Motor Pool;
- xxvi. Travel.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the cost in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.119 Inpatient Administrative Services (IAM)¹

Function: Inpatient Administrative Services are those primarily associated with the overall direction and administration of inpatient services provided in the institution. For example, the hospital admitting office would be assigned to Inpatient Administrative Services; rather than General Administrative Services. Detailed reporting of certain Administrative Services expenses should be provided per N.J.A.C. 8:31B-4, Part VI.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the cost in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.120 Outpatient Administrative Services (OAM)¹

Function: Outpatient Administrative Services are those primarily associated with the overall direction and administration of outpatient services provided in the institution. For example, if an assistant administrator has management responsibility for outpatient areas (i.e., clinic), in addition to the entire hospital plant, then all expenses associated with this assistant administrator must be apportioned between the OAM cost center and the General Administrative Services (GAM) cost center. Detailed reporting of certain Administrative Service expenses should be provided per N.J.A.C. 8:31B-4.131.

¹ In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the cost in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.121 Malpractice Insurance (MAL)

Function: Malpractice Insurance should include the institution's total premium or self-insurance cost for hospital and professional liability coverage. No other type of insurance coverage is to be included here.

8:31B-4.122 Employee Health Insurance (EHI)¹

Function: Employee Health Insurance includes all premium payments and associated costs with union or group health insurance for employees. Hospitals which self-insure for employees, health insurance should report no insurance costs in this cost center; however, deductions from operating revenue for personnel health programs are to be reported by cost center.

¹In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.123 Repairs and Maintenance (RPM)¹**(a) Function:**

1. The Repairs and Maintenance center is responsible for maintenance and operation of an institution's buildings and equipment in a state of readiness required to perform hospital operations. Repairs and Maintenance of physical plant not used for services related to patient care (e.g., rental of apartments) should be reported as reconciliations per N.J.A.C. 8:31B-4, Part IV and N.J.A.C. 8:31B-4.131. Renovation of capital assets is to be distinguished from Repairs and Maintenance Expenses and capitalized with the asset according to the criteria described in N.J.A.C. 8:31B-4.20.

2. The maintenance and repair of specialized equipment in areas such as Diagnostic Radiology, Therapeutic Radiology, or Laboratory should report such costs in those centers. Bio-medical engineers should be treated in this manner.

3. Functions include all maintenance of buildings and plant equipment including painting; maintenance of moveable equipment to the extent done by institution employees; and minor improvements and renovation of buildings and plant equipment.

¹In order to simplify hospital reporting requirements and to allow both SHARE and S.446 reporting requirements to be accommodated in one reporting format, the reporting requirements for this cost center have, in an amendment entitled Uniform Cost Reporting Regulation, been temporarily modified to allow the costs in this cost center to be reported to the Department of Health in the same manner specified in SHARE cost center definitions.

8:31B-4.124 Utilities Cost (UTC)**(a) Function:**

1. The center should be used to account for all utility costs such as electricity, gas, oil, disposal services and water. A breakdown of the cost and source of these utilities should be provided per N.J.A.C. 8:31B-4.131.

2. Telephones are not considered utilities and thus such costs and revenues are not to be reported in this center. Costs associated with utilities provided to buildings and areas not involved in patient care are to be excluded and reported as reconciliations per instructions in N.J.A.C. 8:31B-4.62 through 4.66 and N.J.A.C. 8:31B-4, Part VI.

8:31B-4.125 through 8:31B-4.130 (Reserved)**8:31B-4.131 Financial Elements Report**

The Commissioner of Health shall approve Financial Elements Report forms and reporting instructions consistent with the five Parts of the Financial Elements and Reporting Regulations for completion by all New Jersey hospitals. The Commissioner may refine these report forms for research purposes by adding, modifying, or changing cost centers.

Amended by R.1983 d.596, effective December 19, 1983.
See: 15 N.J.R. 1334(a), 15 N.J.R. 2166(a).

(b) deleted.
Amended by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 5149(a).

SUBCHAPTER 5. (RESERVED)**Subchapter Historical Note**

Subchapter 5 previously contained rules concerning "utilization review", which were recodified as N.J.A.C. 8:31B-3.76 through 3.82 by R.1981 d.494, effective January 4, 1982. See: 13 N.J.R. 486(b), 14 N.J.R. 45(a).

Subchapter 5, Diagnosis Related Groups, was adopted as R.1982 d.27, effective February 1, 1982. See: 13 N.J.R. 726(b), 14 N.J.R. 147(b). The subchapter was amended by the following:

Amended by R.1983 d.595, effective December 19, 1983.
See: 15 N.J.R. 1336(a), 15 N.J.R. 2167(a).

(c) added.

Amended by R.1985 d.122, effective March 18, 1985.
See: 16 N.J.R. 3119(a), 17 N.J.R. 704(a).

Amended by R.1989 d.384, effective July 17, 1989.
See: 21 N.J.R. 138(a), 21 N.J.R. 2088(a).

Administrative correction to (c).
See: 21 N.J.R. 3297(a).

Amended by R.1990 d.265, effective May 21, 1990.
See: 21 N.J.R. 3873(b), 22 N.J.R. 1576(c).

DRGs confirmed to New York State Grouper 7.

Administrative Correction in (c).
See: 22 N.J.R. 308(a).

Amended by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

DRG trim points corrected.

Amended by R.1992 d.43, effective February 3, 1992.
See: 23 N.J.R. 3114(a), 24 N.J.R. 452(a).

High outliers extended to 3 standard deviations from the mean.

Subchapter 5 was repealed by R.1993 d.593, effective November 15, 1993. See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

SUBCHAPTER 6. (RESERVED)

Subchapter Historical Note

Pursuant to N.J.S.A. 26:24-5, Subchapter 6, Mobile Intensive Care Units, was adopted as R.1982 d.38, effective February 16, 1982. See: 13 N.J.R. 647(a), 14 N.J.R. 208(a). Subchapter 6 was repealed by R.1990 d.462, effective September 17, 1990. See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

SUBCHAPTER 7. (RESERVED)

Subchapter Historical Note

Pursuant to P.L. 1986, c.204, N.J.A.C. 8:31B-7.4 and 7.5 became effective March 12, 1987 as Emergency New Rule, R.1987 d.164. See: 19 N.J.R. 568(a).

Subchapter 7, Uncompensated Care Trust Fund, became effective July 20, 1987 as R.1987 d.298. See: 19 N.J.R. 495(a), 19 N.J.R. 1297(a).

N.J.A.C. 8:31B-7.3 was amended by R.1989 d.619, effective December 18, 1989, operative January 1, 1990. See: 21 N.J.R. 2448(a), 21 N.J.R. 3951(b). New Rule 8:31B-7.9 was adopted as R.1989 d.490, effective September 18, 1989. See: 21 N.J.R. 1487(b), 21 N.J.R. 2992(a). New Rule 8:31B-7.10 was adopted on R.1989 d.618, effective December 18, 1989. See: 21 N.J.R. 2923(a), 21 N.J.R. 3971(a). 8:31B-7.3, 7.6 and 7.7 were amended by R.1990 d.462, effective September 17, 1990. See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a). Subchapter 7, Uncompensated Care Trust Fund, was repealed by R.1993 d.668, effective December 20, 1993. See: 25 N.J.R. 3125(a), 25 N.J.R. 6016(a).

APPENDIX I

(RESERVED)

Repealed by R.1993 d.593, effective November 15, 1993.
See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

APPENDIX II

(RESERVED)

Amended by R.1985 d.189, effective April 15, 1985.
See: 17 N.J.R. 153(a), 17 N.J.R. 914(a).

Section substantially amended.

Amended by R. 1985 d.551, effective November 4, 1985.
See: 17 N.J.R. 2000(a), 17 N.J.R. 2633(a).

Labor 1. Proxies completely amended.

Amended by R.1989 d.78, effective February 6, 1989.
See: 20 N.J.R. 2543(a), 21 N.J.R. 297(a).

Changed household linens 40% to Textile home furnishings 40% and household linens 20% to Textile home furnishings 20%.

Amended by R.1989 d.387, effective July 17, 1989.
See: 21 N.J.R. 135(a), 21 N.J.R. 2058(a).

Labor proxy adjustment factor added.

Amended by R.1990 d.462, effective September 17, 1990.
See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Clarification of derivation of economic factor.

Amended by R.1992 d.62, effective February 3, 1992.
See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text deleted.

APPENDIX III

(RESERVED)

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Text at E.-G. deleted; H recodified.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Was "Preliminary Cost Base Report".

APPENDIX IV

(RESERVED)

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Was "Preliminary Cost Base Gross Revenue Requirements".

APPENDIX V

(RESERVED)

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

References to 1980 deleted.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Was "Revenue Budget Worksheet/Submitted Budget Supplied by NJDOH-Completed by Hospital".

APPENDIX VI

(RESERVED)

Administrative Correction to delete "DRG 383" and "Outpatient Dialysis".

See: 22 N.J.R. 3229(b).

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Was "Computation of reasonable direct patient care costs".

APPENDIX VII

(RESERVED)

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Financial elements changed.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Was "Preliminary Cost Base Reconciliation to Net Revenue Related to Patient Care".

APPENDIX VIII

(RESERVED)

Amended by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Dialysis deleted.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

Direct and indirect cost items revised; payer classes introduced.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Was "Schedule of Rates as Adjusted for Compliance".

APPENDIX IX**(RESERVED)**

Amended by R.1989 d.387, effective July 17, 1989.

See: 21 N.J.R. 135(a), 21 N.J.R. 2058(c).

Specification for Rate Years through 1988 added.

Repealed by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Appendix IX, Volume Variability Adjustment, deleted.

APPENDIX X**(RESERVED)**

Repealed by R.1990 d.462, effective September 17, 1990.

See: 22 N.J.R. 1480(a), 22 N.J.R. 3004(a).

Appendix X, Nursing Cost Allocation Methodology, deleted.

APPENDIX XI**(RESERVED)**

Amended by R.1989 d.388, effective July 17, 1989.

See: 21 N.J.R. 1059(a), 21 N.J.R. 2082(a).

Amended by R.1990 d.266, effective May 21, 1990.

See: 22 N.J.R. 735(a), 22 N.J.R. 1591(a).

Medicine—Pediatrics added at I(a)10; Rehabilitation added at 14; DRGs conformed to New York Grouper 7.

Amended by R.1992 d.62, effective February 3, 1992.

See: 23 N.J.R. 3097(a), 24 N.J.R. 425(a).

GME reimbursement methodology revised.

Repealed by R.1993 d.593, effective November 15, 1993.

See: 25 N.J.R. 3117(a), 25 N.J.R. 3566(a), 25 N.J.R. 5149(a).

Was "Reimbursement Methodology for Graduate Medical Education".